

## MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

21587

Village or City Golden Hill (No.)

2 FULL NAME Emma Louise Andrews

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female	4 COLOR OR RACE white	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
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## 6 DATE OF BIRTH

November 18, 1914  
(Month) (Day) (Year)

## 7 AGE

1 yrs. 1 mos. 10 ds. If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Dorchester Co

PARENTS  
10 NAME OF FATHER

Albert Andrews

11 BIRTHPLACE OF FATHER  
(State or country)

Dorchester Co

## 12 MAIDEN NAME OF MOTHER

Addie Fitzhugh

13 BIRTHPLACE OF MOTHER  
(State or country)

Dorchester Co Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Andrews

## (Address)

Golden Hill

Dec 29, 1914

W. J. Lusick  
Local REGISTRAR

15

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 114

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 29, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h. alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Unknown  
no Doctor in Attendance

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Dr. Victor L. Carroll, M.D.  
Dec 29, 1914 (Address) Cambridge

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL St. John's Church yard DATE OF BURIAL Dec 30, 1914

20 UNDERTAKER A. J. Kirwan ADDRESS Braxton

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.) If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.*

RECEIVED

JAN 5 - 1916

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

21588

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 118St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Worfolk (No. —)2 FULL NAME Mary E. Bailey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
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6 DATE OF BIRTH

Dec 14, 1914  
(Month) (Day) (Year)

7 AGE

1 yrs. — m<sup>s</sup>. — ds.If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work. V(b) General nature of industry  
business, or establishment in  
which employed (or employer) V

9 BIRTHPLACE

(State or country) Dorchester Co

PARENTS

10 NAME OF FATHER

John Bailey11 BIRTHPLACE OF FATHER  
(State or country) Dorchester Co

12 MAIDEN NAME OF MOTHER

Yvonne Bryan13 BIRTHPLACE OF MOTHER  
(State or country) Dorchester Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Bailey(Address) Worfolk

15

Filed 14th Dec 1914John R. Jales  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 14, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_\_,

that I last saw h. — alive on \_\_\_\_\_, 191\_\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

My doctor in attend  
suppose from malnutrition(Duration) 70 mos. 0 days.Contributory  
Secondary(Duration) 70 mos. 0 days.(Signed) J. H. Bailey (Address) Worfolk  
Dec 14, 1914, 1914

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Madison

DATE OF BURIAL

Dec 14, 1914

20 UNDERTAKER

John Bailey

ADDRESS

Church Creek

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*", "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

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## 1 PLACE OF DEATH

County Dorchester

21589

Village or City Cambridge (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Henry Anson Barber

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Aug. 20, 1859  
(Month) (Day) (Year)

7 AGE

56 yrs. 4 mos. 11 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work Retired officer U. S. Army  
(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)

Cambridge, Md

10 NAME OF  
FATHER

Theodore P. Barber

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md.

12 MAIDEN NAME  
OF MOTHER

Anna Hooper

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. W. Goddard

(Address) Cambridge, Md

15

Filed Jan 1, 1916

B. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 31, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

in 1915, to 1915, 1915,

that I last saw him alive on Dec 31, 1915, and that death occurred on the date stated above, at 1 P.m.

The CAUSE OF DEATH \* was as follows:

Final decay in his room

History of influenza - Probable

Heart failure

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) B. W. Goddard, M. D.

Dec 1, 1916 (Address) Cambridge, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds.

of death yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Cambridge, Md

## DATE OF BURIAL

Jan 2, 1916

## 20 UNDERTAKER

M. H. Wolff &amp; Sons, Cambridge

## ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is “*Epidemic cerebro-spinal meningitis*”); *Diphtheria* (avoid use of “*Group*”); *Typhoid fever* (never report “*Typhoid pneumonia*”); *Lobar pneumonia*, *Bronchopneumonia* (“*Pneumonia*,” unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; “Cancer” is less definite; avoid use of “Tumor” for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as “Asthenia,” “Anemia” (merely symptomatic), “Atrophy,” “Collapse,” “Coma,” “Convulsions,” “Dobility,” (“Confidential,” “Senile,” etc.), “Dropy,” “Exhaustion,” “Heart failure,” “Haemorrhage,” “Inanition,” “Mara-mus,” “Old Age,” “Shock,” “Uraemia,” “Weakness,” etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as “Puerperal septicæmia,” “Puerperal peritonitis,” etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of “Contributory.” (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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## CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer," is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County..... Dorchester 21591

Village or City..... Salem (No. ....)

<sup>2</sup> FULL NAME..... Louise Jane Brohaun

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX..... Female White <sup>4</sup> COLOR OR RACE..... White

<sup>5</sup> SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

<sup>6</sup> DATE OF BIRTH..... October 12<sup>th</sup>, 1829

(Month) (Day) (Year)

<sup>7</sup> AGE..... 86 yrs. 2 mos. 16 ds.

If LESS than  
1 day ..... hrs.  
OR min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or  
particular kind of work.....

(b) General nature of industry  
business, or establishment in  
which employed (or employer)..... Housekeeper

<sup>9</sup> BIRTHPLACE  
(State or country)..... Maryland

<sup>10</sup> NAME OF  
FATHER..... Garrison Flaherty

<sup>11</sup> BIRTHPLACE  
OF FATHER  
(State or country)..... Maryland

<sup>12</sup> MAIDEN NAME  
OF MOTHER..... unknown

<sup>13</sup> BIRTHPLACE  
OF MOTHER  
(State or country)..... Maryland

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)..... Chas. W. Brohaun (son)

(Address)..... Salem, Md.

Filed Dec 29, 1915

E. W. E. J.

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

St. .... Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH..... December 28, 1915

(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from  
Dec. 18<sup>th</sup>, 1915, to Dec 29<sup>th</sup>, 1915,  
that I last saw her alive on Dec 19<sup>th</sup>, 1915,  
and that death occurred on the date stated above, at ~~W. S. M.~~

The CAUSE OF DEATH \* was as follows:

Chronic Enteritis Appendicitis

(Duration) 9 yrs. — mos. — ds.

Contributory  
Secondary

(Signed) Edward J. Lanier, M. D.  
Dec 28, 1915 (Address) ~~W. S. M.~~

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

In the  
State, ..... yrs. .... mos. .... ds.

<sup>19</sup> PLACE OF BURIAL OR REMOVAL

Salem, Md. DATE OF BURIAL  
Dec 30, 1915

<sup>20</sup> UNDERTAKER

H. H. Willoughby & Son, Market St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County: Somerset

21592

Village or City: Golden Hill (No.)

2 FULL NAME Septimus Brown

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 114

St: \_\_\_\_\_ Ward: \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
6 DATE OF BIRTH		(Month) <u>1</u> (Day) <u>18</u> (Year) <u>31</u>
7 AGE <u>84</u> yrs. — mos. — ds.		It LESS than t day, ___ hrs. OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work: Farming  
 (b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER Nathan Brown  
 11 BIRTHPLACE OF FATHER (State or country) Maryland  
 12 MAIDEN NAME OF MOTHER unknown  
 13 BIRTHPLACE OF MOTHER (State or country) unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin Molack  
 (Address) Golden Hill

15

Filed Dec 23, 1914 W. J. Busick  
 Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 21, 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1914, to Dec 20, 1915,  
 that I last saw him alive on Dec 20, 1915,  
 and that death occurred on the date stated above, at 3 P m.  
 The CAUSE OF DEATH\* was as follows:

Bronchitis pneumonia

(Duration) yrs. mos. 12 ds.  
 Contributory (Secondary) old age

(Duration) yrs. mos. ds.  
 (Signed) Tutor L. Moore, M. D.  
Dec 22, 1915 (Address) Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
 if not at place of death?

Former or usual residence:

19 PLACE OF BURIAL OR REMOVAL Lakesville DATE OF BURIAL Dec 23, 1915

20 UNDERTAKER Dorisay Richardson ADDRESS Church Creek

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

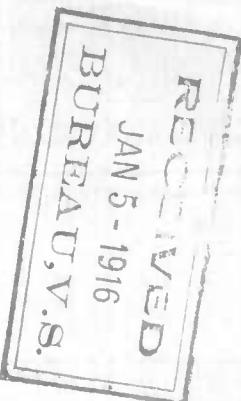
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted terms for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcin-*

*oma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 44; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERAL septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause or death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Dorchester

21593

Village or City Cambridge (No. R. F. D.)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116

119

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thos. Henry Cromwell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WOOED OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH

April 4, 1915  
(Month) (Day) (Year)

7 AGE

8 yrs. 5 mos. 5 ds.  
If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Clerk  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Ind10 NAME OF FATHER Ezekiel J. Cromwell11 BIRTHPLACE OF FATHER  
(State or country) Ind.12 MATURE NAME OF MOTHER Stella Keene13 BIRTHPLACE OF MOTHER  
(State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ezekiel J. Cromwell  
(Address) Cambridge Ind. R. R. D.

15 Died Dec. 10, 1915 Er. Walp.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 9, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
on Nov. 26, 1915, to Nov. 26, 1915,that I last saw him alive on Nov. 26, 1915,  
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH \* was as follows:

Acute nephritis(Burial) Enter - Colitis yrs. mos. ds.Contributory Secondary (Burial) yrs. mos. ds.(Burial) E. E. Wolf yrs. mos. ds.(Signed) Dec. 10, 1915 (Address) Cambridge, Md. yrs. mos. ds.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place Ind to the State, yrs. mos. ds.of death yrs. mos. ds. Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Madison, Ind. DATE OF BURIAL  
Dec. 10, 191520 UNDERTAKER Ervin Baggett ADDRESS  
Cambridge, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is “*Epidemic cerebro-spinal meningitis*”); *Diphtheria* (avoid use of “*Croup*”); *Typhoid fever* (never report “*Typhoid pneumonia*”); *Lobar pneumonia*, *Bronchopneumonia* (“*Pneumonia*,” unqualified, is indefinite); *Tuberculosis of lungs, meningitis*,

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); “*Cancer*” is less definite; avoid use of “*Tumor*” for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as “*Asthenia*,” “*Anaemia*” (merely symptomatic), “*Atrophy*,” “*Col-lapse*,” “*Convulsions*,” “*Debility*,” (“*Con-genital*,” “*Senile*,” etc.), “*Dropsy*,” “*Exhaustion*,” “*Heart failure*,” “*Haemorrhage*,” “*Inanition*,” “*Mara-mus*,” “*Old Age*,” “*Shock*,” “*Uraemia*,” “*Weakness*,” etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as “*PUERPERAL septicæmia*,” “*PUERPERAL peritonitis*,” etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of “*Contributory*.” (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Dorchester 21594

Village or City Williamsburg (No.)

2 FULL NAME James W. Christopher

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
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## 6 DATE OF BIRTH

Jan 22, 1895  
(Month) (Day) (Year)

## 7 AGE

1 yrs. 10 mos. 8 ds.  
If LESS than  
1 day... hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Dorchester Co. Md.

## 10 NAME OF FATHER

William Christopher

11 BIRTHPLACE OF FATHER  
(State or country)

Dorchester Co. Md.

## 12 MAIDEN NAME OF MOTHER

Flora Henry

13 BIRTHPLACE OF MOTHER  
(State or country)

Dorchester Co. Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Christopher

(Address) Wardstock Md.

15 Filed Dec 31<sup>st</sup>, 1915 Robert L. Hastings

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 110

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

(AY)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec. 30, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1915, to Dec. 30, 1915,

that I last saw him alive on Dec. 30, 1915,

and that death occurred on the date stated above, at 9 A.M.  
The CAUSE OF DEATH\* was as follows:

Pneumonia (labor.)

(Duration) yrs. mos. 8 ds.

## Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed) R.G. Tregin, M. D.  
Dec. 31, 1915 (Address) Wardstock Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Williamsburg Md. DATE OF BURIAL Dec. 31<sup>st</sup>, 1915

20 UNDERTAKER H & Williamsby ADDRESS Wardstock Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

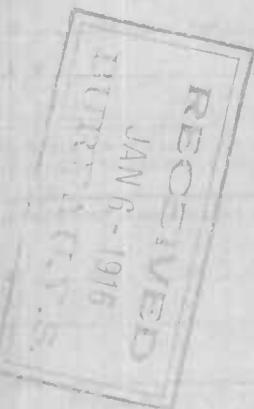
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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Muscles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as "probable" such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probable suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH**  
County Dorchester, 21595

Village or City Federalsburg, Md. (No.)

**2 FULL NAME** Engelia May Carlton

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <u>Female</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <u>—</u>
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**6 DATE OF BIRTH**  
Feb 8, 1907  
(Month) (Day) (Year)

**7 AGE**  
8 yrs. 10 mos. 7 ds. If LESS than  
t day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

**8 OCCUPATION**  
(a) Trade, profession, or  
particular kind of work.  
School  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

**9 BIRTHPLACE**  
(State or country) Dorchester Co., Md.

**10 NAME OF FATHER**  
H. Lee Carlton

**11 BIRTHPLACE OF FATHER**  
(State or country) Dorchester Co., Md.

**12 MAIDEN NAME OF MOTHER**  
Ellie M. Stevens

**13 BIRTHPLACE OF MOTHER**  
(State or country) Dorchester Co., Md.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
I H. Lee Carlton  
(Informant)  
(Address) Federalsburg, Md.

**15** Dec 15<sup>th</sup>, 1915 R. L. L. Hester  
Filed \_\_\_\_\_

REGISTRAR

**STATE OF MARYLAND**  
**CERTIFICATE OF DEATH**

Registration Dist. No. 110

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

(9)

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Dec 15, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from  
Dec 8, 1915, to Dec 14, 1915,

that I last saw her alive on Dec 14, 1915,

and that death occurred on the date stated above, at 4 a.m.,  
The CAUSE OF DEATH\* was as follows:

Delirium

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. G. Drayton, M. D.

12/15/15, 1915. (Address) Federalsburg

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL** Federalsburg **DATE OF BURIAL** Dec 16<sup>th</sup>, 1915

**20 UNDERTAKER** J. T. Franklin & Son **ADDRESS** Federalsburg

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

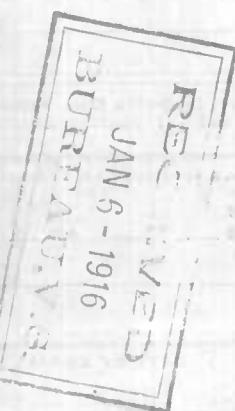
Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc.. *Carcin-*oma, *Sarcoma*, etc., or \_\_\_\_\_ (name origin); "Can-*cer*" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "An-*emia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-*genital*," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mars-*itus*," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septic-*mia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

21596

64

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Cambridge (No. 451, High St.; Ward)

2 FULL NAME Clara Draw

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widow</u>
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6 DATE OF BIRTH <u>Unknown</u>	<u>about</u>	(Month) <u>1840</u>	(Day)	(Year)
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7 AGE <u>about 75</u>	YRS.	MOS.	DS.	If LESS than 1 day, hrs. OR min.?
-----------------------	------	------	-----	---

8 OCCUPATION <input checked="" type="checkbox"/> (a) Trade, profession, or particular kind of work <u>Housewife</u>	<input type="checkbox"/> (b) General nature of industry business, or establishment in which employed (or employer) <u></u>
---	--

9 BIRTHPLACE (State or country) <u>Ind.</u>
--

10 NAME OF FATHER <u>Daniel Barnes</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>
--

12 MAIDEN NAME OF MOTHER <u>Dorothy Eunice</u>
--

13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Doris Johnson</u>
--

(Address) <u>Cambridge, Ind.</u>
----------------------------------

15 Filed <u>Dec. 4, 1915</u> ErWolf
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REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 2, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from not at all, 191..., to 191..., 191...,

that I last saw h. alive on 191..., 191..., and that death occurred on the date stated above, at 8:40 P.M.

The CAUSE OF DEATH \* was as follows:

Apoplexy -  
Very short  
(Duration) yr. mo. de.

Contributory Arter.-Sclerosis  
Secondary

ErWolf, L.R.  
(Signature) Dec. 4, 1915 (Address) Cambridge, Ind.  
(Duration) yr. mo. de.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cambridge, Ind. DATE OF BURIAL Dec. 4, 1915

20 UNDERTAKER Lewis H. Bayneum ADDRESS Cambridge, Ind.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

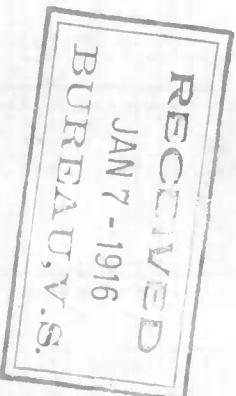
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester 21597  
S

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116Village or City Cambridge

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Derby

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Dec. 6, 1915

(Month)

(Day)

(Year)

7 AGE

Yrs.	Mos.	ds.	OR	min. ?
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## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry business, or establishment to which employed (or employer)

## 9 BIRTHPLACE

(State or country) Md.

## PARENTS

## 10 NAME OF FATHER

Richard J. Derby

## 11 BIRTHPLACE OF FATHER

(State or country) R. I.

## 12 MAIDEN NAME OF MOTHER

Hettie L. Marvel

## 13 BIRTHPLACE OF MOTHER

(State or country) Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard J. Derby(Address) Cambridge P. S. H.

## 15

Filed 12/6/5

C. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec. 6, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from on Dec. 6, 1915, 1915, to Dec. 6, 1915, 1915,that I last saw him alive on Dec. 6, 1915, 1915, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Still-Born

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Henry Steele, M. D.12/6/5 (Address) Cambridge Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. fa fbs  
Where was disease contracted, yrs. mos. ds.  
If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Home Farm DATE OF BURIAL  
12/6, 1915

## 20 UNDERTAKEN

R. J. Derby ADDRESS  
Cambridge

# REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death—Name**, first, the disease causing death (the primary affection with respect to time and causation), using always the same ~~so-called~~ term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29** ds.; *Bronchopneumonia* (secondary), **10** ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal sepihaemic," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning;* *Struck by railway train—accident;* *Revolver wound of head—homicide;* *Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*



## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
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 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

21598

County Dar

(151)

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Cambridge (No. ...., ....)

St.; Ward)

[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]2 FULL NAME Infant Dockins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
<u>Fem. colored</u>		<u>Widowed</u>

6 DATE OF BIRTH

Dec 19, 1915  
 (Month) (Day) (Year)

7 AGE

yrs. mos. 2 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
 particular kind of work(b) General nature of industry  
 business, or establishment in  
 which employed (or employer)9 BIRTHPLACE  
 (State or country)10 NAME OF  
 FATHER11 BIRTHPLACE  
 OF FATHER  
 (State or country)12 MAIDEN NAME  
 OF MOTHER13 BIRTHPLACE  
 OF MOTHER  
 (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Record(Address) Cambridge

15

FRIED Dec 22, 1915 E. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 20, 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec 19, 1915, to Dec 20, 1915,

that I last saw her alive on Dec 20, 1915,  
 and that death occurred on the date stated above, at 10 p.m.

The CAUSE OF DEATH \* was as follows:

Premature Birth

Contributory	Palm. Hemorrhage - prol. Lungs
Secondary	(Duration) yrs. mos. ds.

(Signed)	E. E. Wolff
	(Address) Cambridge, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
 CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
 SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
 OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
 if not at place of death?Former or  
 usual residence

19 PLACE OF BURIAL OR REMOVAL

Cambridge, Dec 22, 1915

DATE OF BURIAL

20 UNDERTAKER

Lewis Baynum, Cambridge, Md.

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County... Baltimore  
Village or City. Lloyd's

21599

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 114

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup> FULL NAMEArthur Hodson

(No.)

(84)

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX <u>Male</u>	<sup>4</sup> COLOR OR RACE <u>White</u>	<sup>5</sup> SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)
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<sup>6</sup> DATE OF BIRTHDec 6, 1915

(Month)

(Day)

(Year)

<sup>7</sup> AGE— yrs.— mos.15 ds.

If LESS than  
1 day, hrs.  
OR min. ?

<sup>8</sup> OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE  
(State or country)Lloyd's

## PARENTS

<sup>10</sup> NAME OF FATHERJohn Hodson<sup>11</sup> BIRTHPLACE OF FATHER  
(State or country)Md<sup>12</sup> MAIDEN NAME OF MOTHERPearl M Vane<sup>13</sup> BIRTHPLACE OF MOTHER  
(State or country)NJ<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Arthur Hodson

16

Filed....., 191.....

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATHDec 21, 1915

(Month)

(Day)

(Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from Dec 6, 1915, to Dec 16, 1915, that I last saw him alive on Dec 16, 1915, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH \* was as follows:

Bronchitis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) S. A. Shatto (Duration) yrs. mos. ds.  
Dec 21, 1915 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death ..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

<sup>19</sup> PLACE OF BURIAL OR REMOVALCambidge Md Dec 22, 1915<sup>20</sup> UNDERTAKERWillis & Bro

## DATE OF BURIAL

## ADDRESS

CambidgeMD

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housenework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonacum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester

21600

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. ....

Village or City Cambridge (No. 171, Washington St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Gladys E. Greene

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Female colored

Single

## 6 DATE OF BIRTH

Mar. 6, 1899

(Month) (Day) (Year)

## 7 AGE

16 yrs. 9 mos. 19 ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

at school

(b) General nature of industry  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

## PARENTS

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER

(State or country)

## THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jacob Greene

(Address) 171 Washington St., Cambridge, Md.

15

Filed Dec. 27, 1915 E. W. G.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 27, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1915, to Nov. 1915, that I last saw her alive on Some time in Nov. 1915, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Tuberculosis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) John Meier, M. D. (Address) Dr. J. H. Corliss

Dr. J. H. Corliss, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Madison, Md.

## DATE OF BURIAL

Dec. 27, 1915

## 20 UNDERTAKER

Lewis L. Fair

## ADDRESS

city

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

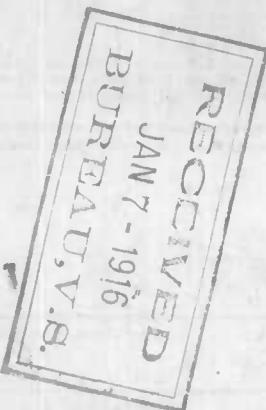
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

*ges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosch*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

**1 PLACE OF DEATH**  
County Oriole 21601

Village or City New Wolford (No. ....)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 118

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME**Bertie J. Harris

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b> <u>Femail</u>	<b>4 COLOR OR RACE</b> <u>Blond</u>	<b>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</b> (Write the word) <u>Married</u>
-------------------------------	--	---

**6 DATE OF BIRTH**

<b>7 AGE</b> <u>27 yrs. — mos. — ds.</u>	If LESS than 1 day.... hrs. OR min.?
---	--

(Month) (Day) (Year)  
....., 1888

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work Housework  
 (b) General nature of industry business, or establishment in which employed (or employer) ✓

**9 BIRTHPLACE**  
(State or country) Oriole Co

**10 NAME OF FATHER**  
John Winter

**11 BIRTHPLACE OF FATHER**  
(State or country) Oriole Co

**12 MAIDEN NAME OF MOTHER**  
Harris

**13 BIRTHPLACE OF MOTHER**  
(State or country) Oriole Co

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Krug Harris  
(Address) New Wolford - MD

15 Filed Dec 11, 1915 John P. Jones  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Dec 10, 1915  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY**, That I attended deceased from Dec 4, 1915, to Dec 10, 1915, that I last saw her alive on Dec 10, 1915, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Acute Consumption of  
Water

Syphilitic (Burial) 4 m. 4 ds.

Contributory Secondary (Burial) 16 m. 0 ds.  
(Signed) Victor G. Gould (Address) Dec 11, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?  
If not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL**

Madison MD DATE OF BURIAL Dec 12, 1915

**20 UNDERTAKER** Lewis & Baynum ADDRESS Cambidge

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—*Death*; *Revolver wound of head*—*homicide*; *Poisoned by carbolic acid*—*probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 5 - 1916

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Dorchester</u>		21602
Village or City <u>Hurlock</u> (No.)		(5)
2 FULL NAME <u>Blanch May Henderson</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Dec 24, 1915</u> (Month) (Day) (Year)		
7 AGE <u>Sheila Bernice</u> yrs.      mos.      ds.	If LESS than 1 day,      hrs. OR      min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed (or employer) <u></u>		
9 BIRTHPLACE (State or country) <u>Md</u>		
10 NAME OF FATHER <u>Henry Henderson</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Del</u>		
12 MAIDEN NAME OF MOTHER <u>Hellen Marne</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hellen Marne</u> (Address) <u>Hurlock, Md</u>		
15 Filed <u>Dec 25, 1915</u> Robert L. Hastings REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 110

St.; Ward)

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH <u>Dec 24, 1915</u> (Month) (Day) (Year)		
17 I HEREBY CERTIFY, That I attended deceased from _____, 191_____, to _____, 191_____, that I last saw h. alive on _____, 191_____, and that death occurred on the date stated above, at /12, m.		
The CAUSE OF DEATH * was as follows: <u>Still Birth</u>		
(Duration) yrs. mos. ds.		
Contributory Secondary <u>Don't Know</u>		
(Duration) yrs. mos. ds.		
(Signed) <u>H. F. Nichols</u> , M. D., 191_____, (Address) <u>8 N. Market St.</u>		
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death      yrs.      mos.      ds.      In the Where was disease contracted, If not at place of death? Former or usual residence		
19 PLACE OF BURIAL OR REMOVAL <u>St. Paul Cemetery</u> DATE OF BURIAL <u>Dec 25, 1915</u>		
20 UNDERTAKER <u>Joe Todd</u> ADDRESS <u>Baltimore</u> <u>Md.</u>		

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

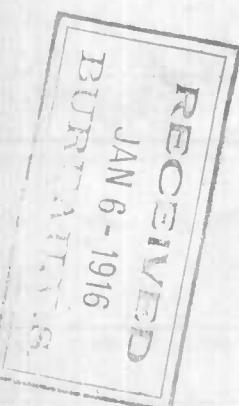
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(name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchoneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reboker wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 6 - 1916



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**1 PLACE OF DEATH**County Dorchester Co.

21643

37

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**Registration Dist. No. 116Village or City Cambridge (No.)Pine St.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME**Nemiah Henry.**PERSONAL AND STATISTICAL PARTICULARS****3 SEX**male**4 COLOR OR RACE**negro**5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)**Married**6 DATE OF BIRTH**March 4

(Month) (Day), 1869 (Year)

**7 AGE**46

yrs. 9 mos. 10 ds.

If LESS than  
1 day, hrs.  
OR min.?**8 OCCUPATION**(a) Trade, profession, or  
particular kind of workMerchant.(b) General nature of industry  
business, or establishment in  
which employed (or employer)**9 BIRTHPLACE**

(State or country)

Madison Md**PARENTS****10 NAME OF FATHER**Henry Henry**11 BIRTHPLACE OF FATHER**

(State or country)

Madison Md**12 MAIDEN NAME OF MOTHER**Mary Rainey**13 BIRTHPLACE OF MOTHER**

(State or country)

Madison Md**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant)

Japhiah Henry

(Address)

Cambridge Md**15**Filed Dec 15, 1915EWJ

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH****16 DATE OF DEATH**December 14, 1915 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from August, 1915, to December 14, 1915, that I last saw him alive on Dec. 14, 1915, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Spiral + Cerebral Syphilis.(Duration) Unknown ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) M. Duke Smith, M. D. Dec 14, 1915 (Address) 138 Race St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In this State, yrs. mos. ds.

Where was disease contracted,

If not at place of death ?

Former or  
usual residence**19 PLACE OF BURIAL OR REMOVAL** nd DATE OF BURIALCambridge nd Dec 16, 1915**20 UNDERTAKER**

ADDRESS

Lewis + Baynes Cambridge nd

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

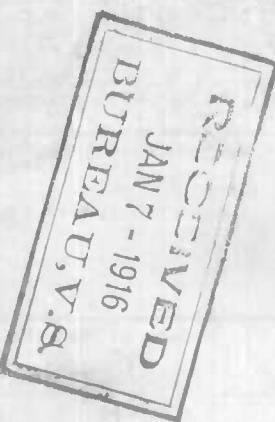
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary engineer*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Lahorier," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullery*, *Cook*, *Housenmaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm(s); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæma*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY SUCH, IF IMPOSSIBLE TO DETERMINE DEFINITELY. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *lethamus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester No. 21604

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116Village or City Lumbwood (No.)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elizabeth Hopkins

## PERSONAL AND STATISTICAL PARTICULARS

<u>3 SEX</u>	<u>4 COLOR OR RACE</u>	<u>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</u>
<u>Female</u>	<u>Black</u>	<u>widow</u>

## 6 DATE OF BIRTH

Dec 27, 1852  
(Month) (Day) (Year)

## 7 AGE

62 yrs. 11 mos. 24 ds. If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work none  
 (b) General nature of Industry business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country)Md.PARENTS  
10 NAME OF FATHERIsaac Banks11 BIRTHPLACE OF FATHER  
(State or country)Md.

## 12 MAIDEN NAME OF MOTHER

Annie Dockins13 BIRTHPLACE OF MOTHER  
(State or country)Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eliza Hopkins(Address) Salem, Md.

## 15

Filed Dec. 22, 1915 E. E. W.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 21, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1915, to Aug. 20, 1915,  
that I last saw her alive on Aug. 20, 1915, and that death occurred on the date stated above, at 11 A.M..  
The CAUSE OF DEATH \* was as follows:

Paralysis(Duration) 6 yrs. mos. ds.Contributory Arteria Schœni  
Secondary(Duration) hrs. min. sec.(Signed) H. F. Nichols, M. D.  
12/22, 1915 (Address) 8 N. Market St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEDIUM OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death years months days. In the State, years months days.

Where was disease contracted,

If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Salem, Md. Date of Burial Dec. 23, 1915

## 20 UNDERTAKER

H. S. Willoughby & N. Market ADDRESS Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

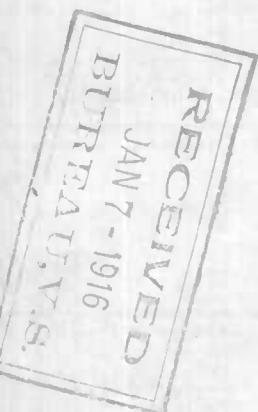
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dye laborer*, *Farm laborer*, *Laborer*—*Cook* *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Smile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester Co.22203  
(155)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 118Village or City Madison (No. \_\_\_\_\_)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Benjamin Hubbard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)
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## 6 DATE OF BIRTH

Feb. 27, 1860  
(Month) (Day) (Year)

## 7 AGE

71 yrs. 6 mos. 4 ds. If LESS than1 day, hrs.  
OR min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer9 BIRTHPLACE  
(State or country)Dorchester Co.

## 10 NAME OF FATHER

Andrew Hubbard11 BIRTHPLACE OF FATHER  
(State or country)Dorchester Co.

## 12 MAIDEN NAME OF MOTHER

Mary Hubbard13 BIRTHPLACE OF MOTHER  
(State or country)Dorchester Co.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Benjamin Hubbard

(Address)

Madison, Md.

15

Filed Jan. 1st, 1916

John R. Fisher

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec. 29, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from 191, to 191,that I last saw h. alive on 191, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Succinct - Probably  
swallowed poison. Character not determined  
No autopsy (Duration) 708 yrs. m. d.Contributory  
SecondaryHarrison Taylor Jr. (Duration) 708 yrs. m. d.  
(Signed) Dec 30, 1915 (Address) Harrison Taylor Jr. M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,

Most al place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Church Creek DATE OF BURIAL Jan. 1, 1916

## 20 UNDERTAKER

Lemonfield-Taylor ADDRESS Cambodge

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *Note*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
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 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

21605

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 116

County DorchesterVillage or City Cambridge (No. 248, Cedar St., Ward)[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]2 FULL NAME Rutha Hughes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)		
<u>Female</u>	<u>colored</u>	<u>Single</u>		
6 DATE OF BIRTH		7 AGE		
<u>Unknown</u>		<u>85</u> yrs.		
		<u>Unknown</u> (Month)	<u>1880</u> (Day)	<u>1915</u> (Year)
		8 mos.	9 ds.	
		If LESS than 1 day, hrs. OR min.?		

10 OCCUPATION (a) Trade, profession, or particular kind of work	<u>Domestic</u>
(b) General nature of industry business, or establishment in which employed (or employer)	

11 BIRTHPLACE (State or country)	<u>Md.</u>
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12 PARENTS 10 NAME OF FATHER	<u>Joseph Hughes</u>
11 BIRTHPLACE OF FATHER (State or country)	<u>Ind.</u>
12 MAIDEN NAME OF MOTHER	<u>Josephine Chase</u>
13 BIRTHPLACE OF MOTHER (State or country)	<u>Ind.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)	<u>Mrs. Jas. Harris</u>
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(Address)	<u>248 Pine &amp; Cedar, Cambridge, Md.</u>
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15 Filed	<u>Dec. 18, 1915</u> — <u>E. Wolf</u>
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REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 18, 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Nov 24, 1915, to Dec 17, 1915,  
 that I last saw her alive on Dec 17, 1915,  
 and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory  
 Secondary

(Signed) Emile E. Korn (Duration) yrs. mos. ds.  
Dec 18, 1915 (Address) Pine & Cedar, M. O.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
 CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
 SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
 OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where disease contracted,  
 If not at place of death? \_\_\_\_\_

In the  
 State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Former or  
 usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cambridge, Md. DATE OF BURIAL Dec. 18, 1915

20 UNDERTAKER Turner & St. Clair ADDRESS city

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

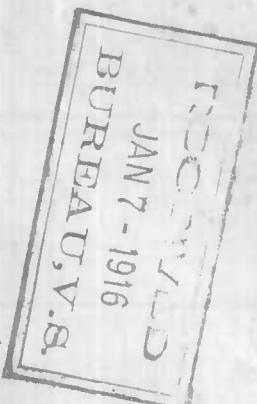
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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *malaria*,

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Manasmus," "Old Age," "Shock," "Uracmia," "Weakness," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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<b>1 PLACE OF DEATH</b>		21606		STATE OF MARYLAND CERTIFICATE OF DEATH	
County	<i>Hanover</i>			Registration Dist. No. 116	
Village or City	<i>Cambridge</i>	<i>Cambridge, Md., Height</i>		St.;	Ward)
<b>182</b>					
<b>2 FULL NAME</b> <i>William Huest</i>					
<b>PERSONAL AND STATISTICAL PARTICULARS</b>					
<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)		<b>MARSHALL</b>	
<b>6 DATE OF BIRTH</b>	<b>7 AGE</b>	<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)	<b>9 BIRTHPLACE</b> (State or country)	<b>10 NAME OF FATHER</b>	<b>11 BIRTHPLACE OF FATHER</b> (State or country)
<i>Male White</i>	<i>41 yrs. 0 mos. 0 ds.</i>	<i>Farmer</i>	<i>Hanover</i>	<i>William Huest</i>	<i>Hanover</i>
<b>12 MAIDEN NAME OF MOTHER</b>	<b>13 BIRTHPLACE OF MOTHER</b> (State or country)	<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) (Address)	<b>15</b> Filled <i>Dec. 26 1915</i>	<b>16 DATE OF DEATH</b>	<b>17</b> Die <i>26</i> , 1915 (Month) (Day) (Year)
<i>Phoebe Wheatley</i>	<i>Hanover</i>	<i>W. H. Huest</i> <i>Secretary, not</i>		<b>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b> At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds Where was disease contracted, if not at place of death? _____ Former or usual residence _____	<b>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b> (Signed) <i>H. F. Meeks</i> (Address) <i>E. N. Market, Md.</i> M. D. <i>Dec. 26, 1915</i>
<b>19 PLACE OF BURIAL OR REMOVAL</b>	<b>DATE OF BURIAL</b>				
<i>E. N. Market, Md.</i>	<i>Dec. 26, 1915</i>				
<b>20 UNDERTAKER</b>	<b>ADDRESS</b>				
<i>W. H. Drivillay, Libby</i>	<i>E. N. Market</i>				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Houswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

### Statement of cause of death

Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JAN 7 - 1916  
BUREAU

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County <u>Dorchester</u>		21607
Village or City <u>Wingate</u>		(No.)
2 FULL NAME <u>Richard Hilga Insley</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>(Write the word)</i> <u>married</u>
6 DATE OF BIRTH <u>February 26</u> (Month) (Day) (Year) <u>1846</u>		
7 AGE <u>69 yrs 9 mos 11 ds.</u>	If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Merchant &amp; Farmer.</u>		
8 OCCUPATION (b) General nature of industry, business, or establishment in which employed (or employer) <u>General Merchantile</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
10 NAME OF FATHER <u>Levin Insley</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
12 MAIDEN NAME OF MOTHER <u>Anderson</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wife &amp; children</u>		
(Address) <u>Wingate Md.</u>		
15 Filed <u>Dec. 8, 1915</u>		W.M. Pittman REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 2119

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

19

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 7  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
March 10, 1915 to Dec 7, 1915,that I last saw him alive on Dec. 7, 1915,and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH★ was as follows:

Chronic Myocarditis(Duration) 2 yrs. mos. ds.Contributory  
Secondary(Duration) 1 yrs. mos. ds.(Signed) P.H. Gage, M. D.  
Dec 8, 1915 (Address) Wingate Md.

★ State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place \_\_\_\_\_ In the  
of death \_\_\_\_\_ yrs. mos. ds. State \_\_\_\_\_ yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence.19 PLACE OF BURIAL OR REMOVAL Wingates DATE OF BURIAL Dec 9, 191520 UNDERTAKER A. J. KinnaneADDRESS Cape May

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compostor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*, *Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*; and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis tetanica*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 - 1916

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

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<sup>1</sup> PLACE OF DEATH  
County Dorchester 21608

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116Village or City Baltimore (No. 10, Light St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup> FULL NAME Floyd E. Pruin

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX <u>Male</u>	<sup>4</sup> COLOR OR RACE <u>White</u>	<sup>5</sup> SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)
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<sup>6</sup> DATE OF BIRTH

June 4<sup>th</sup>, 1894  
(Month) (Day) (Year)

<sup>7</sup> AGE

21 yrs. 6 mos. 2 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR min. ?

<sup>8</sup> OCCUPATION

- (a) Trade, profession, or particular kind of work  
(b) General nature of industry business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE  
(State or country)MarylandPARENTS  
<sup>10</sup> NAME OF FATHERAndrew J. Pruin<sup>11</sup> BIRTHPLACE OF FATHER  
(State or country)Maryland<sup>12</sup> MAIDEN NAME OF MOTHERVictoria Robinson<sup>13</sup> BIRTHPLACE OF MOTHER  
(State or country)Maryland<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE(Informant) Andrew J. Pruin(Address) Baltimore MdFiled Dec 8, 1915 Ernest J. Pruin

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATHDec 6, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from about Nov, 1915, to Dec 6, 1915, that I last saw him alive on Dec 5, 1915, and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

Contributory Ephalton  
Secondary (Duration) yrs. mos. ds.

(Signed) R. W. Galesborow (Duration) yrs. mos. ds.  
Dec 8, 1915 (Address) Baltimore Md, H. U.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where else disease contracted,  
if not at place of death?

Former or  
nearest residence

<sup>19</sup> PLACE OF BURIAL OR REMOVALBaltimore Md

## DATE OF BURIAL

Dec 8<sup>th</sup>, 1915<sup>20</sup> UNDERTAKERJ. H. Miller & Bro.

## ADDRESS

Baltimore Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

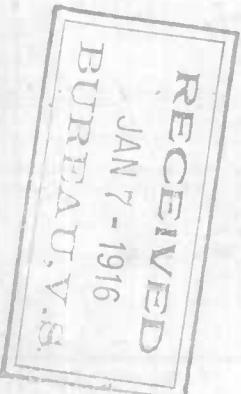
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonymy is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *nem-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS or  
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of  
OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

21609

184

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 110

Village or City New Haven (No.)

St.: Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]2 FULL NAME Mattie G. Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>black</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Print the word)
---------------------	------------------------------	---

## DATE OF BIRTH

Oct 11      24, 1915  
(Month)      (Day)      (Year)

6 AGE  
yrs. 22 mos. 0 ds.      If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 7 OCCUPATION

- (a) Trade, profession, or particular kind of work None
- (b) General nature of industry business, or establishment in which employed (or employer) None

8 BIRTHPLACE  
(State or country)

## PARENTS

## 10 NAME OF FATHER

Waltis Jackson11 BIRTHPLACE OF FATHER  
(State or country)Dorchester

## 12 MATURE NAME OF MOTHER

Maryall Jones13 BIRTHPLACE OF MOTHER  
(State or country)Dorchester

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mattie Jackson(Address) 7 Harbor Street15 Date Dec 17<sup>th</sup>, 1915 Robert L. Hastings

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 17, 1915, 1915  
(Month)      (Day)      (Year)

17 I HEREBY CERTIFY, That I attended deceased from no time, 1915, to no time, 1915,  
that I last saw h. alive on no date,  
and that death occurred on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH \* was as follows:

Not known  
did not see victim before death

Contributory  
Secondary

(Duration)      yrs.      mos.      ds.

(Signed) G. Roy Myers M. D.  
12/17/15, 1915 (Address) 7 Harbor Street

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted,  
if not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Washington

## 20 UNDERTAKER

Robert L. Hastings

## DATE OF BURIAL

Dec 18, 1915

## ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County..... Village or City.....		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. .... 116	
2 FULL NAME..... Infant Jones		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single	
6 DATE OF BIRTH Dec. 9 <sup>th</sup> , 1915 (Month) (Day) (Year)		10 DATE OF DEATH Dec. 9, 1915 (Month) (Day) (Year)	
7 AGE yrs. .... m <sup>s</sup> . ....	If LESS than 1 day, hrs. OR min. ?	11 I HEREBY CERTIFY, That I attended deceased from 191... to 191... that I last saw h alive on 191... and that death occurred on the date stated above, at m. The CAUSE OF DEATH * was as follows:	
		Still-Birth	
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		(Duration) yrs. m <sup>s</sup> . ds.	
9 BIRTHPLACE (State or country) Md.		Contributory Secondary	
10 NAME OF FATHER John W. Jones		(Signed) On Glashow, 1915 (Address) Cambridge	
11 BIRTHPLACE OF FATHER (State or country) Md.		* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
12 MAIDEN NAME OF MOTHER James Etta West		13 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
13 BIRTHPLACE OF MOTHER (State or country) Va.		At place of death yrs. m <sup>s</sup> . ds.	In the State, yrs. m <sup>s</sup> . ds.
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____			
15 Filed Apr. 29, 1916 E. E. Wolff REGISTRAR		16 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191... 17 UNDERTAKER ADDRESS	

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

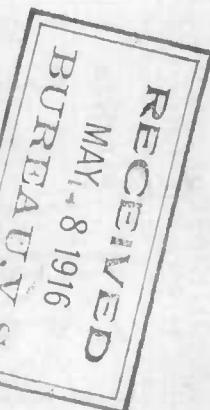
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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar meningitis*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

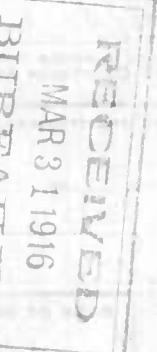
APR 28 1916

COPY SENT TO LOCAL REGISTRAR NO. 116 DATE



ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Dorchester

21610

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 110Village or City Williamsburg (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Mona T. Jump

## PERSONAL AND STATISTICAL PARTICULARS

<u>3 SEX</u>	<u>4 COLOR OR RACE</u>	<u>5 SINGLE, MARRIED, WIDWED OR DIVORCED</u> (Write the word)
<u>Female</u>	<u>White</u>	<u>married</u>

## 6 DATE OF BIRTH

May 1, 1890  
(Monthly) (Day) (Year)

## 7 AGE

25 yrs. 7 mos. 6 ds.If LESS than  
1 day, hrs.  
OR min?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

House - work9 BIRTHPLACE  
(State or country)Md.

## 10 NAME OF FATHER

Burg E. WhalleyMd.Md.

## 11 BIRTHPLACE OF FATHER

(State or country)

Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

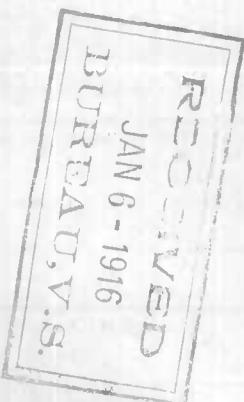
[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Mumps*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Semile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marauderous," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæma," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Dorchester

21611

169

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

St.: Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

Village or City Cambridge (No. 105, Street) Hair

2 FULL NAME Elija J. Keene

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>Widow</i>
------------------------	---------------------------------	---

6 DATE OF BIRTH  
*unknown*  
(Month) (Day) (Year)  
....., 1.....

7 AGE  
*About 65* yrs. mos. ds.  
If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.....  
*None*  
(b) General nature of industry  
business, or establishment in  
which employed (or employer).....

9 BIRTHPLACE  
(State or country)  
*Maryland*

10 NAME OF  
FATHER  
*John Albin*

11 BIRTHPLACE  
OF FATHER  
(State or country)  
*Maryland*

12 MATURE NAME  
OF MOTHER  
*Rebecca Diffenderfer*

13 BIRTHPLACE  
OF MOTHER  
(State or country)  
*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Mr. John Fletcher*

(Address) Cambridge 2nd

15 Died Dec. 24, 1915 E. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*Dec 23rd, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
....., 191....., to ..... 191.....,

that I last saw h..... alive on ..... 191....., and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH \* was as follows:

*Cancer Vagina*  
Dead when physician saw her  
N.P.

(Duration) yrs. mos. ds.

Contributory *Cancer Vagina*  
Secondary

(Duration) yrs. mos. ds.

(Signed) *Chas W. Stanley* (Address) *208 Nightingale*  
M. D.

Dec. 24, 1915 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. Is the State, yrs. mos. ds.

Where disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*Cambridge 2nd* DATE OF BURIAL  
Dec. 24th, 1915

20 UNDERTAKER

*H. H. Miller & Sons* ADDRESS  
Cambridge 2nd

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

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V. S. No. 1.  
**N. B.**—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

**1 PLACE OF DEATH** *Dorchester* **21612** **(S)** **STATE OF MARYLAND**  
**CERTIFICATE OF DEATH**

**Registration Dist. No.** *116*

**County** *Cambridge* **(No.)**, **St.; Ward** *Md* **[If death occurred in a hospital or institution, give its NAME instead of street and number.]**

**2 FULL NAME** *No name LeCompte*

<b>PERSONAL AND STATISTICAL PARTICULARS</b>				
<b>3 SEX</b> <i>Male</i>	<b>4 COLOR OR RACE</b> <i>White</i>	<b>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</b> <i>Single</i> <small>(Write the word)</small>		
<b>6 DATE OF BIRTH</b> <i>December 9, 1915</i> <small>(Month) (Day) (Year)</small>				
<b>7 AGE</b> <small>yrs. mos. 0 ds.</small>				
If LESS than 1 day, hrs. OR min.?				
<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work <i>Steel barn</i> (b) General nature of industry business, or establishment in which employed (or employer) <i>None</i>				
<b>9 BIRTHPLACE</b> (State or country) <i>Cambridge Md</i>				
<b>10 NAME OF FATHER</b> <i>Henry H. LeCompte</i>				
<b>11 BIRTHPLACE OF FATHER</b> <i>Maryland</i> (State or country)				
<b>12 MAIDEN NAME OF MOTHER</b> <i>L. May Wiley</i>				
<b>13 BIRTHPLACE OF MOTHER</b> <i>Maryland</i> (State or country)				
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <i>Henry H. LeCompte</i> (Address) <i>Cambridge Md</i>				
<b>15 Filed</b> <i>Dec. 9, 1915</i> <b>Elewoff</b>				
<b>REGISTRAR</b>				
<b>16 DATE OF DEATH</b> <i>Dec. 9, 1915</i> <small>(Month) (Day) (Year)</small>				
<b>17 I HEREBY CERTIFY, That I attended deceased from</b> <i>Not at all</i> , 1915, to 1915, that I last saw h. alive on 1915, and that death occurred on the date stated above, at 12 m.				
<b>The CAUSE OF DEATH</b> * was as follows: <i>Still-born.</i>				
<small>(Duration) yrs. mos. ds.</small>				
<b>Contributory</b> Secondary				
<small>(Duration) yrs. mos. ds.</small>				
<b>(Signed)</b> <i>Elewoff S. R.</i> <small>M. O.</small> <b>Dec. 9, 1915</b> <b>(Address)</b> <i>Cambridge Md</i>				
<small>* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.</small>				
<b>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b> At place of death yrs. mes. ds. In the State, yrs. mos. ds.				
Where disease contracted, if not at place of death?				
Former or usual residence				
<b>19 PLACE OF BURIAL OR REMOVAL</b> <i>Md</i> <b>DATE OF BURIAL</b> <i>Wilson Farm near Lloyds</i> <b>Dec. 9, 1915</b>				
<b>20 UNDERTAKER</b> <i>LeCompte &amp; Harper</i> <b>ADDRESS</b> <i>Cambridge Md</i>				

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Mousmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester

21613

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 111

Village or City Cambridge

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

William F. Lewis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Male White

Married

6 DATE OF BIRTH

December, 1858

(Month) (Day) (Year)

7 AGE

63

yrs. — mos. — ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

Brieroyer

9 BIRTHPLACE

(State or country)

Dorchester Co., Md

## PARENTS

10 NAME OF  
FATHER

John Lewis -

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Rebecca McGehee

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E.S. State Hospital record

15

(Address)

Cambridge Md

Filed Dec 3, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec

2, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY That I attended deceased from

July 8, 1915, to Dec 2, 1915,  
that I last saw him alive on Dec 2, 1915,

and that death occurred on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH \* was as follows:

Cerebral

(Duration) yrs. mos. ds.

(Signed) Dr. Holcomb N. O.

Dec 2, 1915 (Address) Cambridge

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. 6 mos. 13 ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

Cambridge Md

19 PLACE OF BURIAL OR REMOVAL

E.S. State Hospital Cemetery  
Cambridge Md

DATE OF BURIAL

Dec 4, 1915

20 UNDERTAKER

Lecompte &amp; Harper

ADOREBS

Cambridge  
Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may he entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullion*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Colic", "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 7 - 1916

BUREAU, V.S.

JAN 7 - 1916

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester

21614

(92)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 111Village or City Secretary (No. )St.  Ward 

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Maronick

## PERSONAL AND STATISTICAL PARTICULARS

<u>3 SEX</u>	<u>4 COLOR OR RACE</u>	<u>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</u> (Write the word)
<u>Female</u>	<u>White</u>	<u>Married</u>

6 DATE OF BIRTHOct. 13, 1887  
(Month) (Day) (Year)7 AGE58 yrs. 1 mos. 17 ds.If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION  
 (a) Trade, profession, or  
 particular kind of work House-work  
 (b) General nature of industry  
 business, or establishment in  
 which employed (or employer)

9 BIRTHPLACE  
(State or country) Austria Europe10 NAME OF FATHERJohn Merrick11 BIRTHPLACE OF FATHER  
(State or country) Austria Europe12 MAIDEN NAME OF MOTHERUnknown13 BIRTHPLACE OF MOTHER  
(State or country) Austria Europe14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE(Informant) Albert Maronick(Address) Secretary, Md.

15

Filed 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATHDec. 1, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Nov. 10, 1915, to Nov. 30, 1915;  
that I last saw her alive on Nov. 30, 1915,  
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory Chronic nephritis  
Secondary

(Duration) yrs. mos. ds.

(Signed) H. F. Nichols M. O.  
(Address) 8 N. Market St., 191

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_. mcs. \_\_\_\_\_. ds. In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_. mcs. \_\_\_\_\_. ds. State, \_\_\_\_\_ yrs. \_\_\_\_\_. mcs. \_\_\_\_\_. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Secretary, Md. DATE OF BURIAL  
See 3, 1915

20 UNDERTAKER

H. H. Willoughby & Son, market ADDRESS  
10th

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer*, *Farm laborer*, *Laborer in coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY AS ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY SUCH, IF IMPOSSIBLE TO DETERMINE DEFINITELY. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

**N.B.—** Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

21615

County *Oxonian Co., Md.*

(X)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City *Pembroke (No 405 miles)*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Alfred H. Meenick*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>Married</i>
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## 6 DATE OF BIRTH

*July 8 1843*

(Month) (Day) (Year)

## 7 AGE

*77 yrs. 9 mos. 24 ds.*If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Retired Farmer*

(b) General nature of industry business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

*Oxonian Co., Md.*

## PARENTS

## 10 NAME OF FATHER

*Huckwadon*

## 11 BIRTHPLACE OF FATHER

*Oxonian Co., Md.*

## 12 MAIDEN NAME OF MOTHER

*Yorkinane*

## 13 BIRTHPLACE OF MOTHER

*Oxonian Co., Md.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Dec. 3, 1915

E. Elswell

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*Dec 7, 1915*

(Month)

(Day)

(Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

*—, 1915, to Dec 1, 1915,*that I last saw him alive on *Dec 1, 1915*,and that death occurred on the date stated above, at *12 m.*

The CAUSE OF DEATH \* was as follows:

*conciusion of stomach**metastasis, glands stomach**from pyloric stenosis**liver*

(Signed)

*17/3, 1915 (Address) Cambridge, Md.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Vineyard Cemetery*

## DATE OF BURIAL

*Dec 4, 1915*

## 20 UNGERTAKER

*Lamfor Harped Cambridge, Md.*

## ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer*—*Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc, Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report incipient symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæma," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County *Dorchester Co.*

21616

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *114*Village or City *Springs* (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*William H. Miller*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male.</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <i>MARRIED</i> (Write the word)
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## 6 DATE OF BIRTH

*July 29, 1882*  
(Month) (Day) (Year)

## 7 AGE

*83 yrs. 4 mos. 18 ds.* If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work

*Farmer*  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

## 10 NAME OF FATHER

*William H. Miller*11 BIRTHPLACE OF FATHER  
(State or country)*Dorchester Co.*

## 12 MAIDEN NAME OF MOTHER

*Clara Miller*13 BIRTHPLACE OF MOTHER  
(State or country)*Dorchester Co.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Gerry Phillips*(Address) *Florida road*

## 15

*Dec 19, 1915 W. J. Leurich*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*Dec 17, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Nov 8, 1915*, to *Dec 16, 1915*, that I last saw him alive on *Dec 16, 1915*, and that death occurred on the date stated above, at *12 a.m.* The CAUSE OF DEATH \* was as follows:

*Rheumatic Florida*  
(Duration) yrs. *10 mos.* ds.

Contributory  
Secondary

(Signed) *Victor Bassett Cambridge*  
(Signature) *Dec 17, 1915* (Address) *M. D.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death yrs. mos. ds.  
Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Lakenvill* DATE OF BURIAL  
*Dec 19, 1915*

## 20 UNDERTAKER

*A. J. Kirwan* ADDRESS  
*crapo*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. ~~Never~~ report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

21617

(156)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Cambridge (No.) Locust St., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Sarah E. Mitchell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <input checked="" type="checkbox"/> Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single
---	--------------------------	---

## 6 DATE OF BIRTH

Oct. 6<sup>th</sup>, 1863  
(Month) (Day) (Year)

## 7 AGE

52 yrs. 2 mos. ds.

If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work Housekeeper
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Maryland

## 10 NAME OF FATHER

Richard H. Mitchell

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Georgiana Seward

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alexander Mitchell

(Address) Cambridge Md.

15

Filed Dec. 7, 1915 - E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec. 6, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Jan. 27, 1915, to Dec. 5, 1915,

that I last saw her alive on Dec. 5, 1915,

and that death occurred on the date stated above, at 7:45 p.m.

## The CAUSE OF DEATH \* was as follows:

Inhalation of chloroform gas  
Supposedly suicide  
N.B. (Duration) yrs. mos. ds.Contributory  
Secondary(Signed) John Wm. Campbell  
(Address) Dec. 6, 1915

(Duration) yrs. mos. ds.

M. O.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Cornersville Md. DATE OF BURIAL  
Dec. 7<sup>th</sup>, 1915

## 20 UNDERTAKER

H. H. Willis & Bro. ADDRESS  
Cambridge Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer* —*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (unrely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

21618

County Dar.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Aireys

(No. 4)

St. Ward)

(5)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

R. F. D.

Infant Nabb.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

males white

Infant

6 DATE OF BIRTH

Dec 30, 1915

(Month)

(Day)

(Year)

7 AGE

If LESS than  
1 day, hrs.  
yrs. mos. ds. OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)

Md

10 NAME OF  
FATHER

Geo. B. Nabb

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Hattie C. Johnson

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Birth Certificate.

(Address)

15

Filed Dec. 30, 1915 Deed

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 30, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 1915, to , 1915,

that I last saw h alive on , 1915, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Prematurity  
BirthStill-Birth  
(Duration) yrs. mos. ds.Contributory  
SecondarySunstroke  
(Duration) yrs. mos. ds.

(Signed) 1915 (Address) Cambridge Md. M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place yrs. mos. ds. Is the  
of death Where was disease contracted,  
If not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Aireys

DATE OF BURIAL

Dec 31, 1915

20 UNDERTAKER

Geo B Nabb

ADDRESS

Aireys  
Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dry laborer*, *Farm laborer*, *Laborer* —*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Hausfrau*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmied*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *cataract*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester

21619

Q5

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 112

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Vienna (No.)

Laura J. Neal

2 FULL NAME Laura J. Neal

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)
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## 6 DATE OF BIRTH

May 25, 1860.  
(Month) (Day) (Year)

## 7 AGE

55 yrs. 6 mos. 0 ds.

If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER Edward Christopher  
 11 BIRTHPLACE OF FATHER Md.  
 (State or country)

12 MAIDEN NAME OF MOTHER Emily Henry  
 13 BIRTHPLACE OF MOTHER Md.  
 (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Isaac M. Neal (husband)  
 (Address) Vienna, Md.

15 DEC 5 - 1915 191 Edward E. Lankin  
 Filed Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 4, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1915, to Dec 4, 1915,  
that I last saw her alive on Dec 4, 1915,  
and that death occurred on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH was as follows:

Cobar Pneumonia(Duration) — yrs. — mos. 4 ds.Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) E.S. Hunt, M. D.  
Dec 5, 1915 (Address) Vienna, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
 of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted,  
 if not at place of death ?  
 Former or  
 usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL  
DEC 5 - 1915  
Vienna, Md.20 UNDERTAKER  
Le Compte & Harper ADDRESS  
Cambridge, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Colton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Gold mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonitis, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report more symptoms or terminal conditions, such as "*Asthma*," "*Anaemia*" (morely symptomatic), "*Atrophy*," "*Col-lapse*," "*Convulsions*," "*Debility*" ("*Con genital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marusmus*," "*Old Age*," "*Shock*," "*Uremia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Ruptured wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "*Contributory*." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 8 - 1916

BURTAU, V.S.

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**  
**N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.**

## 1 PLACE OF DEATH

Dorchester

21620

County \_\_\_\_\_

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Cambridge (No. \_\_\_\_\_)

(S)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME Anfist — Phillips

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDDED  
OR DIVORCED  
(Write the word)

White -

6 DATE OF BIRTH

Dec 20  
(Month) (Day), 1915  
(Year)

7 AGE

— yrs. — mos. — ds.  
If LESS than  
1 day. hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

Now

9 BIRTHPLACE  
(State or country)

Cambridge

PARENTS

10 NAME OF  
FATHER

Floyd Phillips

11 BIRTHPLACE  
OF FATHER  
(State or country)

Lakes

12 MAIDEN NAME  
OF MOTHER

Edith Miller

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Lakes

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Floyd Miller

(Address)

Cambridge

15

Filed Dec 20, 1915 Edward

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 20 —  
(Month) (Day), 1915  
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_\_,

that I last saw h — alive on \_\_\_\_\_, 191\_\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Shell Corn

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) John \_\_\_\_\_, M. D.

Dec 20, 1915 (Address) Cambridge

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place \_\_\_\_\_ yrs. mos. ds.  
of death \_\_\_\_\_ yrs. mos. ds.  
Where was disease contracted,  
if not at place of death?In the  
State, \_\_\_\_\_ yrs. mos. ds.Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Laurelville, Md. Dec 21, 1915

DATE OF BURIAL

20 UNDERTAKER

Lewinsport Haven ADDRESS  
Cambridge

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary engineer, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer*—*Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1 PLACE OF DEATH**  
County Dorchester

21621

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 115

Village or City Fishing Creek (No. 5)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME**

(Sue Birth)

Phillips

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)
Male	white	single

**6 DATE OF BIRTH**

Dec. 21, 1915  
(Month) (Day) (Year)

**7 AGE**

0 yrs. 0 mos. 0 ds.  
If LESS than  
1 day, 0 hrs.  
OR 0 min. ?

**8 OCCUPATION**

(a) Trade, profession, or  
particular kind of work. None  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) ✓

**9 BIRTHPLACE**(State or country) Maryland**10 NAME OF FATHER**Jerimia M. Phillips**11 BIRTHPLACE OF FATHER**(State or country) Dorchester Co. Md.**12 MAIDEN NAME OF MOTHER**Alexanda S. Aaron**13 BIRTHPLACE OF MOTHER**(State or country) Dorchester Co. Md.**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**(Informant) Martia Aaron(Address) Fishing Creek, Md.15 Filed Dec. 28, 1915 James W. Meade

Deputy Local REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**Dec. 21, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Dec. 21, 1915, to ✓, 1915that I last saw him alive on ✓, 1915and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH\* was as follows:

Sue Birth

(Duration) ✓ yrs. ✓ mos. ✓ ds.  
Contributory Difficult Labor (Period  
Secondary uterine gestation 9 mos

(Duration) ✓ yrs. ✓ mos. ✓ ds.  
(Signed) James W. Meade, M. D.

Dec. 21, 1915 (Address) Fishing Creek, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**At place of death ✓ yrs. ✓ mos. ✓ ds. In the State ✓ yrs. ✓ mos. ✓ ds

Where was disease contracted, if not at place of death?

Former or usual residence.

**19 PLACE OF BURIAL OR REMOVAL**Hosier Memorial Cemetery DATE OF BURIAL Dec. 29, 1915**20 UNDERTAKER**Jerimia M. Phillips ADDRESS Fishing Creek, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

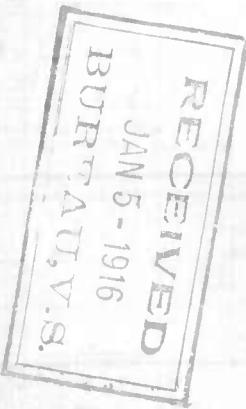
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester

21622

(A)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 119

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Vienna (No. ,2 FULL NAME Hillis Pinder

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX	<sup>4</sup> COLOR OR RACE	<sup>5</sup> SINGLE, MARRIED, WIDOWED OR DIVORCED
<u>Male</u>	<u>Black</u>	<u>Divorced</u>

<sup>6</sup> DATE OF BIRTH About 1852

(Month) 1 (Day) 1 (Year)

<sup>7</sup> AGE About 63 yrs

yrs. .... mos. .... ds. ....

If LESS than  
1 day, hrs.  
OR min. ?<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE  
(State or country)<sup>10</sup> NAME OF FATHER<sup>11</sup> BIRTHPLACE OF FATHER  
(State or country)<sup>12</sup> MAIDEN NAME OF MOTHER<sup>13</sup> BIRTHPLACE OF MOTHER  
(State or country)<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE(Informant) G. Allen Pinder(Address) Vienna, Md.

15

Filed 1915 Edward E. Langham  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 6, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1915, to Dec 5, 1915,that I last saw him alive on Dec 5, 1915, and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH \* was as follows:

Bronchitis pneumonia

(Duration) — yrs. — mos. — ds.

Contributory Acute attack of Chronic  
Secondary Cystitis

(Duration) — yrs. — mos. — ds.

(Signed) E. E. Langham, M. D.12-6-1915 (Address) Vienna, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

In the State, yrs. mos. ds.

## 19 PLACE OF BURIAL OR REMOVAL

Vienna, Md. DATE OF BURIAL 12/8/15, 1915

## 20 UNDERTAKER

Meloughby & Son ADDRESS Burlock, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Collon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm labore*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *Note*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . ("name origin"; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Mara-nitus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 8 - 1916

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

1 PLACE OF DEATH  
County Dorchester

21623

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Taylorsbridge(No. 55, State Hagerst St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Theodore F. Parker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Married
Neale White			
6 DATE OF BIRTH		Ago 29, 1837	
		(Month)	(Day)
		(Year)	
7 AGE		78	7 29
		Yrs.	Mos. ds.
		If LESS than 1 day, hrs. OR min.?	

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Fisherman  
 (b) General nature of industry business, or establishment in which employed (or employer) Fishing Industry

9 BIRTHPLACE  
(State or country) Maryland10 NAME OF FATHER Theodore F. Parker11 BIRTHPLACE OF FATHER  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Ann Nessige13 BIRTHPLACE OF MOTHER  
(State or country) Maryland14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Records  
(Address)15 Filed Dec. 28, 1915 By E. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 28, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1915, to Dec 28, 1915,  
that I last saw him alive on Dec 28, 1915,  
and that death occurred on the date stated above, at W.M.A.

The CAUSE OF DEATH \* was as follows:

Myocarditis  
(Duration) Dec 28, 1915 to Dec 28, 1915

Contributory  
Secondary

(Signed) J. C. Poland (Address) Taylorsbridge  
(Duration) Dec 28, 1915 to Dec 28, 1915 M. O.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da. In the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

Where disease contracted,  
if not at place of death? Tyaskin, Md.

Former or usual residence Tyaskin, Prince George Co., Md.

19 PLACE OF BURIAL OR REMOVAL Tyaskin, Md. DATE OF BURIAL Dec. 30, 191520 UNDERTAKER H. H. Miller & Sons. ADDRESS Cambidge, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

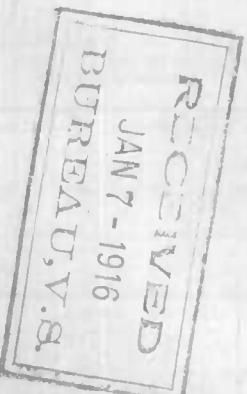
**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmama*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosches*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (morely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *læthargy*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County.....		21624	STATE OF MARYLAND CERTIFICATE OF DEATH	
Dorchester		Q.R.	Registration Dist. No. 116	
Village or City.....		No. Cambridge	St.;	Ward)
2 FULL NAME.....		Edwin W. Price	[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single	MEDICAL CERTIFICATE OF DEATH	
6 DATE OF BIRTH.....		July 22, 1911 (Month) (Day) (Year)	16 DATE OF DEATH Dec. 3, 1915 (Month) (Day) (Year)	
7 AGE 4 yrs. 11 mos. 11 ds.		If LESS than 1 day, hrs. OR min. ?	17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1915, to Dec 1, 1915, that I last saw him alive on Dec. 1, 1915, and that death occurred on the date stated above, at m. The CAUSE OF DEATH * was as follows: <i>Pneumonia</i>	
8 OCCUPATION (a) Trade, profession, or particular kind of work..... (b) General nature of industry business, or establishment in which employed (or employer)..... Infant		(Duration) yrs. mos. ds.		
9 BIRTHPLACE (State or country) Maryland		Contributory Secondary <i>Hemorrhage</i> (Duration) yrs. mos. ds.		
10 NAME OF FATHER W.M.H. Price		(Signed) J. H. Swan, M. O.		
11 BIRTHPLACE OF FATHER (State or country) Maryland		Date of death, 1915 (Address) Condufer		
12 MAIDEN NAME OF MOTHER Lucy M. Parks		State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
13 BIRTHPLACE OF MOTHER (State or country) Maryland		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. do. Where was disease contracted, if not at place of death? Former or usual residence		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W.M.H. Price		In the State, yrs. mos. ds.		
(Address) Cambridge Md		19 PLACE OF BURIAL OR REMOVAL Greenlawn Cem. Cambridge, Md. Date of Burial Dec. 5, 1915		
15 Filed Dec 4, 1915 DeWolfe		20 UNDERTAKER L. Compton & Hailey Cambridge Md ADDRESS		
REGISTRAR				

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

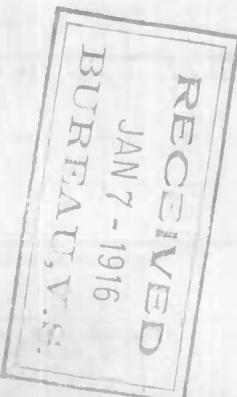
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosites*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæma," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<b>1 PLACE OF DEATH</b>		
County	Dorchester 21625	
<b>Village or City</b> E N Market (No.)		
<b>2 FULL NAME</b> James Mitchell Reid		
<b>PERSONAL AND STATISTICAL PARTICULARS</b>		
<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)
Male	White	married
<b>6 DATE OF BIRTH</b>		<b>7 AGE</b>
Jan 21 - 1846,		69 yrs. 10 mos. 18 ds.
		If LESS than t day, ____ hrs. OR ____ min. ?
<b>8 OCCUPATION</b>		<b>9 BIRTHPLACE</b> (State or country)
(a) Trade, profession, or particular kind of work.		Dorchester md
(b) General nature of industry, business, or establishment in which employed (or employer)		Harmer
<b>10 NAME OF FATHER</b>		<b>11 BIRTHPLACE OF FATHER</b> (State or country)
Wm Reid		Dorchester md
<b>12 MAIDEN NAME OF MOTHER</b>		<b>13 BIRTHPLACE OF MOTHER</b> (State or country)
dorit brown		Md.
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>		
(Informant) James Reid		
(Address) 222 Fernmont Terrace		
15 Filed	191	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 111

St. Ward

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Dec 11, 1911  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1911, to Dec. 11, 1911, that I last saw him alive on Dec. 11, 1911, and that death occurred on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH\* was as follows:

Cancer of Prostal Gland.

(Duration) 1 yrs. 6 mos. ds.  
Contributory Dail-Know Secondary

(Duration) yrs. mos. ds.  
(Signed) H. F. Nichols, M. D., 191 (Address) E. N. Market md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)**

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

**19 PLACE OF BURIAL OR REMOVAL** E N Market  
**DATE OF BURIAL** Dec 13 1913

**20 UNDERTAKER** H. J. Mullingsby  
**ADDRESS** E N Market

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

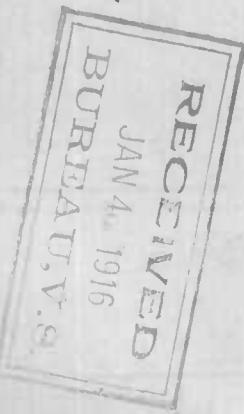
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maugger," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer-Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Houswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the illness causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *N.o.c.*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, icterus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester 22201 (No.)

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 116

## Village or City

Cambridge (No.) Hosp.

St.; Ward)

[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]

## 2 FULL NAME

A. G. Butterhouse

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

## 6 DATE OF BIRTH

(Month) (Day) (Year)

April 6, 1872

## 7 AGE

42 yrs. 9 mos. 15 ds.

If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

Farmer

Farm Worker

## 9 BIRTHPLACE

(State or country)

Maryland

## 10 NAME OF FATHER

Nathanial Butterhouse

## 11 BIRTHPLACE OF FATHER

(State or country)

Ohio

## 12 MAIDEN NAME OF MOTHER

Mary Anna Farmer

## 13 BIRTHPLACE OF MOTHER

(State or country)

Ohio

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lula A. Butterhouse

(Address)

Hurstock, Md. R. F. D.

## 15

Filed Dec. 24, 1915

E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 24, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
 July 21, 1915, to Dec 24, 1915,  
 that I last saw him alive on 1915,  
 and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH \* was as follows:

Heart disorder  
 Surgical operation

(Duration) yrs. mcs. ds.

Contributory Secondary Septicemia

(Duration) yrs. mcs. ds.  
 (Signed) G. E. Webb M.D. (Address) Preston, Md.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
 CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
 SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
 OR RECENT RESIDENTS)At place  
 of death yrs. mcs. ds.  
 Where was disease contracted,  
 if not at place of death?  
 Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Hurstock, Md

## DATE OF BURIAL

Dec 26, 1915

## 20 UNDERTAKER

Harry Hollis

## ADDRESS

Preston, Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colon* *mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return: "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Gruop"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumonia*, *Pronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

22202

County

Dorchester

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City

Cambridge Md. Hospital

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

George Robinson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male white

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED-  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

June 29  
(Month) (Day), 1859  
(Year)

7 AGE

56 yrs. 5 mos. 20 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

Oysterman

9 BIRTHPLACE

(State or country)

Dorchester Co

## PARENTS

10 NAME OF FATHER

Albert-Robinson

11 BIRTHPLACE OF FATHER  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Sophia Robinson

13 BIRTHPLACE OF MOTHER  
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emery Robinson

(Address)

Lakes

15

Filed Dec 18, 1915

Edw. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 18, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1915, to Dec 17, 1915; that I last saw him alive on Dec 17, 1915; and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH \* was as follows:

Neuritis Syphilitic

(Duration) yrs. 2 mos. - ds.

Contributory  
Secondary

Specific

(Duration) yrs. mos. - ds.

(Signed) W. H. Howell, M. D.  
Dec 18, 1915 (Address) Cambridge

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Crags, Md.

DATE OF BURIAL

Dec 19, 1915

20 UNDERTAKER

LeCompte Harper Cambridge  
Md

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

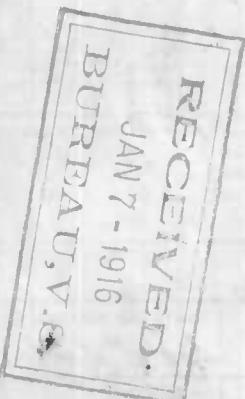
[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

gcs, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uterine," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**1 PLACE OF DEATH**  
County Dorchester

21626

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**Registration Dist. No. 115

(S)

St. ✓ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Hoopersville (No. ✓)

Ross

**2 FULL NAME** Still Birth**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <u>unknown</u>	<b>4 COLOR OR RACE</b> <u>Colored.</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> <u>Single</u> (Write the word)
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<b>6 DATE OF BIRTH</b>		
<u>Dec.</u>	<u>9</u>	<u>, 1915</u>
(Month)	(Day)	(Year)

<b>7 AGE</b>		
<u>0</u>	yrs.	mos.
<u>0</u>	ds.	OR min. ?

<b>8 OCCUPATION</b>		
(a) Trade, profession, or particular kind of work. <u>✓</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>		

<b>9 BIRTHPLACE</b> (State or country)		
<u>Maryland</u>		

<b>10 NAME OF FATHER</b>		
<u>Major Ross</u>		

<b>11 BIRTHPLACE OF FATHER</b> (State or country)		
<u>Maryland</u>		

<b>12 MAIDEN NAME OF MOTHER</b>		
<u>Florence Tavers</u>		

<b>13 BIRTHPLACE OF MOTHER</b> (State or country)		
<u>Maryland</u>		

<b>14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>		
(Informant) <u>Annie Ross</u>		

(Address) <u>Hoopersville, Md.</u>		
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15	Filed <u>Dec 10, 1915</u>	James W. Meade
----	---------------------------	----------------

Deputy Local REGISTRAR
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**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Dec. 9, 1915, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1915, to Dec. 9, 1915,

that I last saw him alive on Dec. 9, 1915,

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH was as follows:

Premature Birth — (Duration) 2 days yrs. 0 mos. 0 ds.

Contributory Period of Ulcer & Cystitis 1 weeks  
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) James W. Meade, M.D.  
Dated Dec. 10, 1915 (Address) Hopkins Creek, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL** John Hopkins Medical School **DATE OF BURIAL** Dec. 10, 1915

**20 UNDERTAKER** Dr. Franklin P. Mall **ADDRESS** Baltimore, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

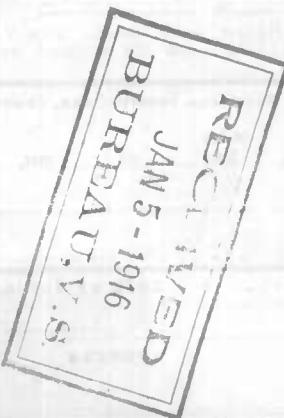
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

### Statement of cause of death

Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

*oma, Sarcoma*, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<b>1 PLACE OF DEATH</b>		21627	
County	Dorchester		
Village or City	Hoopersville (No.)		
<b>2 FULL NAME</b>			
Infant Ruark			
<b>PERSONAL AND STATISTICAL PARTICULARS</b>			
<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)</b>	
Female	White	Infant	
<b>6 DATE OF BIRTH</b>	December 18th, 1915		
	(Month)	(Day)	
		(Year)	
<b>7 AGE</b>	0 yrs.	0 mos.	0 ds.
	If LESS than 1 day, <u>4</u> . hrs. OR.....min. ?		
<b>8 OCCUPATION</b>			
(a) Trade, profession, or particular kind of work	Infant		
(b) General nature of industry, business, or establishment in which employed (or employer)	Infant		
<b>9 BIRTHPLACE (State or country)</b>	Dorchester Co., Maryland		
<b>10 NAME OF FATHER</b>	Lannie F. Ruark		
<b>11 BIRTHPLACE OF FATHER (State or country)</b>	Middlesex County, Virginia		
<b>12 MAIDEN NAME OF MOTHER</b>	Tergie P. Travers		
<b>13 BIRTHPLACE OF MOTHER (State or country)</b>	Dorchester County, Maryland		
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>	(Informant) Mrs. Tergie P. Ruark		
	(Address) Hoopersville, Ind.		
<b>15</b>	Filed Dec. 18th, 1915 <u>W.H. Hennington</u> Local REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 110-

(15)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<b>MEDICAL CERTIFICATE OF DEATH</b>			
<b>16 DATE OF DEATH</b>	December 18th, 1915		
(Month)	(Day)	(Year)	
I HEREBY CERTIFY, That I attended deceased from			
Dec. 18th, 1915	to	Dec. 18th, 1915	
that I last saw her alive on Dec. 18th, 1915.			
and that death occurred on the date stated above, at 12 m.,			
The CAUSE OF DEATH* was as follows:			
Premature delivery gestation 6 mos. 20 days.			
(Duration) yrs. mos. ds.			
<b>Contributory Secondary</b>	Influenza in mother		
(Duration) yrs. mos. ds.			
(Signed) <u>W.H. Hennington</u> , M.D.	Dec. 18th, 1915 (Address) Fishing Creek, Ind.		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
<b>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b>			
At place	To the		
of death	yrs.	mos.	ds.
Where was disease contracted,			
If not at place of death?			
Former or usual residence.			
<b>19 PLACE OF BURIAL OR REMOVAL</b>	<b>DATE OF BURIAL</b>		
Fishing Baying ground	Dec. 20th, 1915		
Hooperville, Ind.			
<b>20 UNDERTAKER</b>	<b>ADDRESS</b>		
W.M. Finnegan & Co.	Fishing Creek, Ind.		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid housekeepers who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester

21628

(R.Y.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 111

Village or City E. N. Market (No. ....)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emmerson Sampson

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX <u>Male</u>	<sup>4</sup> COLOR OR RACE <u>Black</u>	<sup>5</sup> SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u>
------------------------------	---	---

## 6 DATE OF BIRTH

Sept. 19, 1910  
 (Month) (Day) (Year)

## 7 AGE

2 mos. 28 ds.  
 yrs.      mos.      ds.  
 If LESS than  
 1 day, hrs.  
 OR min.?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work none  
 (b) General nature of industry business, or establishment in which employed (or employer) None

9 BIRTHPLACE  
(State or country)Md

## 10 NAME OF FATHER

Albert Johnson11 BIRTHPLACE OF FATHER  
(State or country)Md

## 12 MAIDEN NAME OF MOTHER

Sadie Sampson13 BIRTHPLACE OF MOTHER  
(State or country)Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt. Sampson(Address) E. N. Market Md

## 15

Filed ..... , 191.....

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 16, 1915  
 (Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

, 191....., to , 191.....,

that I last saw h. — alive on , 191.....,

and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH \* was as follows:

Pneumonia Labor

(Duration) yrs. mos. 3 ds.

Contributory  
Secondary

(Signed) H. F. Woods, M. D.  
 (Address) E. N. Market Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.  
 Where disease contracted,  
 If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Thompson Town, Dec 17, 1915

## 20 UNDERTAKER

H. H. Willoughby, E. N. Market, Md

## DATE OF BURIAL

## ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumonia*, *Pneumonitis* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

"ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæma*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 4 1916

BUREAU, U.S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester 21629  
S

Village or City E.N. market (No. ....)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 111

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Thos. Sampson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Dec. 10, 1915  
(Month) (Day) (Year)

7 AGE

— yrs. — mos. — ds.

If LESS than  
1 day. hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

none

(b) General nature of Industry  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Md.

## PARENTS

## 10 NAME OF FATHER

Joseph H Sampson

## 11 BIRTHPLACE OF FATHER

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Mary Mathews

## 13 BIRTHPLACE OF MOTHER

(State or country)

Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph H Sampson

(Address)

E.N. market Md

15

Filed ..... , 191.....

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec. 10, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191....., to ..... , 191.....

that I last saw h. alive on ..... , 191.....

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH \* was as follows:

still born

(Duration) yrs. mos. da.

Contributory Don't know  
Secondary

(Duration) yrs. mos. da.

(Signed) H. F. Nichols, M. D. (Address) E.N. market Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT

CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_

of death ..... yrs. ..... mos. ..... da. State, ..... yrs. ..... mos. ..... da.

Where was disease contracted,  
If not at place of death ?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Joseph H Sampson Dec. 10, 1915

## 20 UNDERTAKER

Jos. H Sampson ADDRESS E.N. market

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

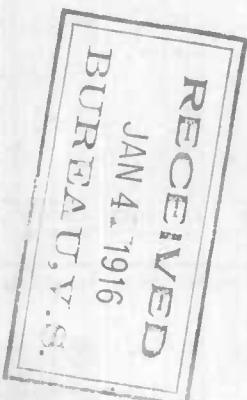
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

(ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH  
County Dorchester

21630

Village or City Taylor's Isld'd (No. ....)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 113

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emma d' Schnoor

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
----------------	---------------------------	---

## 6 DATE OF BIRTH

May 3, 1913  
(Month) (Day) (Year)

7 AGE 2 yrs. 7 mos. 17 ds. If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work None  
(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF  
FATHER Martin Schnoor  
11 BIRTHPLACE  
OF FATHER  
(State or country) Germany  
12 MAIDEN NAME  
OF MOTHER Emma Marx  
13 BIRTHPLACE  
OF MOTHER  
(State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Schnoor  
(Address) Taylor's Isld'd

15 Filed Dec 21, 1915 Jos. K. Shriver & Son  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 21, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
....., 191..., to ..... , 191...  
that I last saw h ..... alive on ..... , 191...  
and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH \* was as follows:

Diphtheria

(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary  
(Signed) Jos. K. Shriver, Jr. (Address) Taylor's Isld'd  
Dec 21, 1915 (Date) M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) METHODS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds.  
Where was disease contracted,  
if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethlehem cem. DATE OF BURIAL Dec 21, 1915

20 UNDERTAKER Henry W. Lambdin ADDRESS Taylor's Isld'y

**CERTIFICATE OF DEATH**

Approved by U. S. Centers and American Public Health Association]

#### **Statement of Occupation—Precise statement of occupation.**

If the certificate is looked over thoroughly and all dues are paid in full, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

It is a certificate over the signature of the American Medical Association, on statement of cause of death approved by Committee on Mortality, at the head of "Contributor," (Recommendations and consequences (e. g., sepsis, tumors) may be stated and circled). The nature of the injury, as far as skull fracture, spinal cord, etc., is circled. The head-hemorrhage; Positively circled by circulate and probably caused by cerebral brain—accident; Reader wounded to determine definitely. Examples: Accidental drowning; surgical means of injury and accidentally as accidental, state means of operation was undertaken. For violent deaths suggest cause of death such as homicide, birth or misce-

genital, "Premature peritonitis," etc. State cause for which subject, or homicidal, or as probability such as "Premature septicemia," "Premature septicemia," etc. Always qualify all diseases resulting from child cause, when a definite disease can be ascertained as the cause, "Old Age," "Shock," "Urnia," "Weakness," "Mus," "Heart failure," "H. convulsions," "Inflammation," "Malaria," "Epilepsy," "Senile," "Dropsy," "Debility," "Convulsions," "Con-

gestive," "Coma," "Hypotension," "Astrophy," "Col-  
lapse," "Anæmia" (merely symptomatic), "Asthenia," symptoms often report mere changes (secondary), 10 ds. Never report more than one disease (primary), 20 ds. Bron-

chopneumonia (secondary), 10 ds. Never report more than one disease (primary), 20 ds. Chronic interstitial nephritis, etc. The contributory secondary of interstitial nephritis, etc. Chronic tubular heart disease; Chronic tubular nephritis; "Tumor," for malignant neoplasms; Measles; Whooping cough; Chrotic rachitic, etc. Avoid use of name (name, "Cancer," is less definite; avoid use of dashes, peritonitis, etc., Carcinoma, Sarcoma, etc., of

(a) Salesman, (b) (c) (trotter, (d) Foreman, (e) Laborer, (f) Auto-mobile factor. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as Day laborer, Farm laborer, Laborer, Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewives. Housework, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed given up on account of the disaster caused by fire, flood, business, etc., that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever.

**Statement of Occupation—** Precise statement of occupation is very important, so that the relative healthful- ness of various pursuits can be known. The question applies to each and every person, irrespective of age. To many occupations a single word will be sufficient, e.g., Farmer or Planter, Physi- cian, Composer, Architect,Locomotive engineer, Civil engineer, Shipowner, firmman, etc. But in many cases, it should be used for the latter statement; it should be used business or industry, and therefore an additional line know (a) the kind of work and also (b) the nature of the business especially in industrial emigrations; it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

21631

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116

(R)

Village or City Antioch- (No. ....)

St.; Ward)

Henson2 FULL NAME Infant Seymour

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
-------------------	--------------------------------	---

6 DATE OF BIRTH		
Nov.	30	, 1915
(Month)	(Day)	(Year)

7 AGE		
YRS. ....	MOS. <u>26</u>	DS. ....
If LESS than 1 day, ____ hrs. OR ____ min. ?		

8 OCCUPATION		
(a) Trade, profession, or particular kind of work <u>None</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		

9 BIRTHPLACE (State or country) <u>Ind</u>		
---	--	--

10 NAME OF FATHER <u>Dick Seymour</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>		
12 MAIDEN NAME OF MOTHER <u>Susie Henson</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Signature) <u>Dick Seymour</u>		
---	--	--

(Address) <u>Cambridge, Ind. R. F. D.</u>		
---	--	--

15 Filed <u>Dec 27, 1915</u> by <u>E. E. Wolfger</u>		
--	--	--

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 26, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from not at all, 1915, to 1915,

that I last saw him alive on 1915, 1915;

and that death occurred on the date stated above, at 80 m.

The CAUSE OF DEATH \* was as follows:

Broncho-Pneumonia.

Contributory Pneumonia  
Secondary Secondary

(Duration) yrs. mos. ds.  
(Signed) E. E. Wolfger (Address) Ind (Duration) yrs. mos. ds.  
Dec. 27, 1915 (Address) Cambridge, Ind. (Duration) yrs. mos. ds.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Antioch, Ind. DATE OF BURIAL Dec. 27, 1915

20 UNDERTAKER La Caugh Harper ADDRESS Cambridge, Ind.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

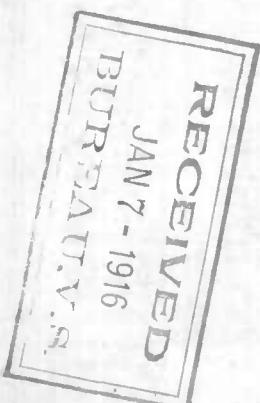
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer — Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housenmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meningitis*,

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Mendes* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Deficiency," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**  
**N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.**

## 1 PLACE OF DEATH

County Dorchester

21632

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116Village or City Cambridge (No. 564 Douglas St.; Ward)[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## 2 FULL NAME

Mary V. Shookley

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

Female colored

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

## 6 DATE OF BIRTH

July 30, 1914  
(Month) (Day) (Year)

## 7 AGE

1 yrs. 4 mos. 8 ds.

If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work Infant
- (b) General nature of industry business, or establishment in which employed (or employer) None

## 9 BIRTHPLACE

(State or country)

## PARENTS

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Shookley(Address) 564 Douglas Cambridge Md.

## 15

Filled Dec. 8, 1915 by Erdwaff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 8th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1915, to Dec 8th, 1915, that I last saw her alive on Dec 8th, 1915, and that death occurred on the date stated above, at 7:15 p.m.

The CAUSE OF DEATH \* was as follows:

PneumoniaContributory General debility  
SecondaryGeneral debility  
(Duration) yrs. 7 mos. 17 days(Signed) John Lyman Bell, M.D.  
Dec 8th, 1915 (Address) Cambridge Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT REBONENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted,  
It not at place of death? \_\_\_\_\_Former or  
usual residence \_\_\_\_\_In the  
State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## 19 PLACE OF BURIAL OR REMOVAL

Cambridge Md. Dec 9, 1915

## 20 UNDERTAKER

Turner & H. C. Clark ADDRESS city

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

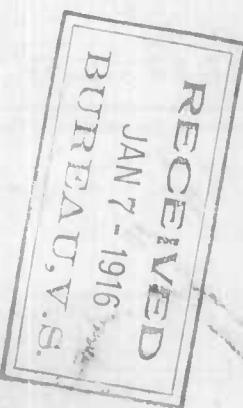
**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Term laborer*, *Laborer*—*Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housenmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid* fever (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intermediate) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**  
**N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.**

**1 PLACE OF DEATH**  
 Dorchester County 21633

Village or City Near Hudson (No.)

**STATE OF MARYLAND  
 CERTIFICATE OF DEATH**

Registration Dist. No. 119

St.; Ward)

[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]

**2 FULL NAME** William E. Spudden

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> Male	<b>4 COLOR OR RACE</b> White	<b>5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)</b> Married
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**6 DATE OF BIRTH**

July 14<sup>th</sup>, 1857  
 (Month) (Day) (Year)

**7 AGE**

62 yrs. 4 mos. 29 ds.

If LESS than  
 1 day, hrs.  
 OR min.?

**8 OCCUPATION**

- (a) Trade, profession, or  
 particular kind of work  
 Farmer
- (b) General nature of industry  
 business, or establishment in  
 which employed (or employer)

**9 BIRTHPLACE  
 (State or country)**

Maryland

Thomas Spudden

**PARENTS**

**10 NAME OF  
 FATHER**

Maryland

**11 BIRTHPLACE  
 OF FATHER  
 (State or country)**

Thomas Spudden

**12 MAIDEN NAME  
 OF MOTHER**

Maryland

**13 BIRTHPLACE  
 OF MOTHER  
 (State or country)**

Ann Spudden

Maryland

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs Fannie Spudden

(Address) Todd's Point

15

Filed....., 191.....

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Dec. 13 — , 1915  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
 ..... to Dec. 12, 1915,  
 that I last saw him alive on Dec. 11, 1915,  
 and that death occurred on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH \* was as follows:

Sept. 18

Contributory  
 Secondary

(Duration) yrs. 2 mos. 00 days.

(Signed) John Willis, M. D.

Present Address: 1015 Cambridge Street, Baltimore, Md.  
 State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
 CAUSES, state (1) Means of INJURY; and (2) whether ACCIDENTAL,  
 SUICIDAL or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
 OR RECENT RESIDENTS)**

In the  
 place  
 of death ..... yrs. ..... mos. ..... ds.  
 Where was disease contracted,  
 if not at place of death?  
 Former or  
 usual residence

**19 PLACE OF BURIAL OR REMOVAL**

Todd's Point

**DATE OF BURIAL**

Dec. 15<sup>th</sup>, 1915

**20 UNDERTAKER**

W. H. Willis & Bro.

**ADDRESS**

Cambridge and

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer* —*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be cited as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 4 1916

DITR. A.U.V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Worchester</u>		21634
Village or City <u>Church Creek</u>		(No.)
2 FULL NAME <u>Bernard Lecompte Spier</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Oct - 11, 1913</u> (Month) (Day) (Year)		
7 AGE <u>2 yrs. 2 mos. 18 ds.</u>	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>woman</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u></u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
10 NAME OF FATHER <u>Bernard Spier</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
12 MAIDEN NAME OF MOTHER <u>Vivian Jones</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Bernard Spier</u> (Address) <u>Church Creek</u>		
15 Filed <u>Dec 26, 1915</u>	John R. Johnson	REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 118St.  Ward 

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 24, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1915, to Dec 24, 1915,

that I last saw him alive on Dec 24, 1915,

and that death occurred on the date stated above, at 11 a.m..  
The CAUSE OF DEATH\* was as follows:

Minimis longi.

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Barrell, M. D.  
Dec 24, 1915 (Address) Lambertown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Church Creek DATE OF BURIAL Dec 26, 1915

20 UNDERTAKER Bernard Richardson

ADDRESS Church Creek

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*oma, *Sarcoma*, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**  
JAN 5 - 1916  
BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County..... Dwcherly

21635

Village or CITY..... Salem (No.)

2 FULL NAME Wm H. Storr

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

<u>3 SEX</u>	<u>4 COLOR OR RACE</u>	<u>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</u>	<u>Married</u>
<u>Male</u>	<u>white</u>		

<u>6 DATE OF BIRTH</u>	<u>7</u>	<u>Feb.</u>	<u>1845</u>
	(Month)	(Day)	(Year)

<u>8 AGE</u>	<u>47 yrs.</u>	<u>10 mos.</u>	<u>-</u>	<u>ds.</u>
	11 LESS than			
	1 day, <u>hrs.</u>			
	OR	<u>min.?</u>		

<u>8 OCCUPATION</u>	<u>(a) Trade, profession, or particular kind of work.</u>	<u>Retired former</u>
	<u>(b) General nature of industry business, or establishment in which employed (or employer)</u>	<u>—</u>

<u>9 BIRTHPLACE</u> (State or country)	<u>Md</u>
---	-----------

<u>10 NAME OF FATHER</u>	<u>Mrs. Storr</u>
--------------------------	-------------------

<u>11 BIRTHPLACE OF FATHER</u> (State or country)	<u>Md</u>
--	-----------

<u>12 MAIDEN NAME OF MOTHER</u>	<u>Unknown</u>
---------------------------------	----------------

<u>13 BIRTHPLACE OF MOTHER</u> (State or country)	<u>Unknown</u>
--	----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. A. Storr

(Address) Salem Md

15 Filed Dec. 25, 1915 E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 25, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred on the date stated above, at 6:30 m.

The CAUSE OF DEATH \* was as follows:  
Chronic interstitial nephritis

(Duration) 2 yrs. mo. ds.

Contributory  
Secondary

(Signed) E. Wolff (Address) Cambridge Md.  
(Duration) 6 mo. mo. ds.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death yrs. mes. ds. In the  
State, yrs. mes. ds.

Where disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL East New Market, Md DATE OF BURIAL Dec. 27, 1915

20 UNDERTAKER Howard Willoughby ADDRESS East New Market, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

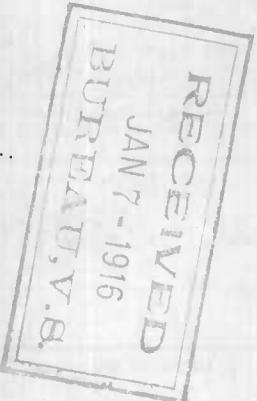
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dry laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, menin-

gosis, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæma," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *lethamis*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

Village or City Woolford (No.)

2 FULL NAME Harriet A. Thomas

21636

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 118

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Widow</u>

6 DATE OF BIRTH  
Do not know, 1  
(Month) (Day) (Year)

7 AGE  
About 70 yrs. m<sup>s</sup>. d<sup>s</sup>. If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work  
None  
(b) General nature of industry  
business, or establishment in  
which employed (or employer)  
None

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF  
FATHER James J. Brannock

11 BIRTHPLACE  
OF FATHER  
(State or country) Maryland

12 MAIDEN NAME  
OF MOTHER Elizabeth Woolford

13 BIRTHPLACE  
OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Charles Seward  
(Address) Oxford Md.

15 Filed Dec. 20, 1915 John P. Juler

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Dec. 17, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Dec. 15, 1915, to Dec. 15, 1915;  
that I last saw her alive on Dec. 15, 1915;  
and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH \* was as follows:

Aortic Insufficiency  
(Duration) four days yrs. mos. ds.

Contributory  
Secondary

(Signed) Victor Glauert, M. D.  
(Address) Cambridge, M. D.  
Dec. 18, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place  
of death yrs. mos. ds. In the  
State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL  
Sea Church Creek DATE OF BURIAL  
Dec. 20<sup>th</sup>, 1915

20 UNDERTAKER  
H. H. Willis & Son ADDRESS  
Cambridge Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

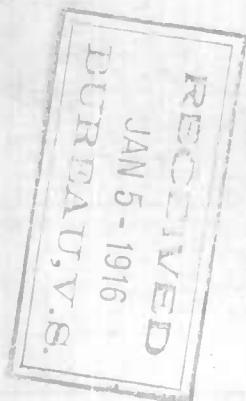
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dye laborer*, *Farm laborer*, *Laborer — Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Convalescence," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ileum*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



RECEIVED  
JAN 5 - 1916  
BUREAU, V.S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Dorchester 21637

Village or City Henslock (No. ....)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 110

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

William Thomas

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Doesnt Know  
(Month) (Day) (Year)

7 AGE Doesnt Know  
yrs. m<sup>s</sup>. ds. If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work Labourer  
(b) General nature of industry  
business, or establishment in  
which employed (or employer) Born work

9 BIRTHPLACE  
(State or country) Talbot County Md

10 NAME OF  
FATHER Doesnt Know

11 BIRTHPLACE  
OF FATHER  
(State or country) Doesnt Know

12 MAIDEN NAME  
OF MOTHER Doesnt Know

13 BIRTHPLACE  
OF MOTHER  
(State or country) Doesnt Know

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

1 (Informant) Chas D Hastings

(Address) Henslock Md

15 Filed Dec 2<sup>nd</sup>, 1915 Robert L Hastings

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 17  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
11/17, 1915, to 11/17, 1915,  
that I last saw him alive on 11/17, 1915,  
and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Record Disease

Contributory none  
Secondary

(Duration) yrs. mos. da.  
(Signed) E Rogers (Signature) yrs. mos. da.  
M. D. Henderson (Address) 11/17, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place  
of death yrs. mos. da.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL Henslock Md DATE OF BURIAL  
Dec 2<sup>nd</sup>, 1915

20 UNDERTAKERS Mansfield Thompson ADDRESS Henslock Md

**CERTIFICATE OF DEATH**

[Approved by U. S. Census and American Public Health Association.]

#### **Statement of Occupation—Precise statement of occupation**

Statement of Cause of Death—Name, first, the disease  
causing death (the primary affection with respect to  
time and causation), using always the same accepted  
term for the same disease. Examples: Cerebrospinal  
fever (the only definite synonym in spinal meningitis);  
Diphtheria (avoid use of "Croup");  
Tuberculosis of lungs, never report "Typhoid pneumonia";  
Lobar pneumonia ("Pneumonia");  
Spinal meningitis; Bronchopneumonia ("Pneumonia");  
Tuberculosis of bone (never use of "Tuberculosis");  
Sarcoid, etc. For persons who have no occupation whatever,  
6 yrs.). For persons who have no occupation whatever,  
businesses, their fact may be indicated thus: Farmer (retired  
state occupation at beginning of illness. If retired from  
or given up on account of the disease causing death,  
Housemaid, etc. If the occupation has been changed  
or engaged in domestic service for wages, as Servant, Cook,  
Housewife, or Housekeeper, may be entered as House-  
wife, Housework, or At Home, and children, not gainfully  
employed, as At school or At home. Care should be  
taken to report specifically the occupations of persons  
who receive a definite salary, may be entered as House-  
keepers of the household only (not paid housekeepers  
—Coal mine, etc. Women at home, who are engaged in  
the duties of the household only (not paid housekeepers  
—Farming, Farm laborer, Laborer, Farmer, etc., without more  
precise specification as Day laborer, Farm laborer, Farmer,  
Farm wife, etc. Without more  
of the second statement. Never return "Laborer",  
"Foreman", "Manager", "Dealer", etc., to form part  
mobile factory. The material worked on may form part  
of the second statement. Never return "Laborer",  
"Foreman", (a) Sackman, (b) Grocer; (a) Foreman, (b) Auto-  
mill;

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

21638

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 115

Village or City Fishing Creek (No.)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

John Lee Travers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>April 24th.</u>		(Month) (Day) (Year) <u>1874</u>
7 AGE <u>41 yrs. 8 mos. 14 ds.</u>		If LESS than 1 day, _____.hrs. OR _____.min.?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Oysterman - Carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer) Oysterman - Carpenter

9 BIRTHPLACE  
(State or country) Dorchester County - Maryland

10 NAME OF FATHER Thos. Henry Travers

11 BIRTHPLACE OF FATHER  
(State or country) Dorchester County - Maryland

12 MAIDEN NAME OF MOTHER Catharine Lewis

13 BIRTHPLACE OF MOTHER  
(State or country) Dorchester County - Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Orlia Adams

(Address) Fishing Creek, Md.

15 Dec. 15th., 1915 Filed W.H. Houston, Md.  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 15th., 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from December 4th, 1915 to December 15th, 1915.

that I last saw him alive on December 14th, 1915.

and that death occurred on the date stated above, at 1 P.M.,  
The CAUSE OF DEATH\* was as follows:

Typhoid Fever  
(Duration) yrs. 2 mos. 8 ds.

Contributory  
Secondary

(Duration) yrs. 0 mos. 0 ds.

(Signed) W.H. Houston, M.D.  
Dec. 15th., 1915 (Address) Fishing Creek, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. To the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Fishing Creek, Md.  
Travers Burial Ground DATE OF BURIAL Dec. 17th., 1915

20 UNDERTAKER W.H. Simmons & Co. ADDRESS Fishing Creek, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housenwife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the misfortune causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the misfortune causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.; *Carcin-*

*oma, Sarcoma*, etc., of.....; (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County... Dorchester Co.

21639

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City... Lambsden P. O.

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Graves.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

D.C. 16, 1913  
(Month) (Day) (Year)

7 AGE

yrs. mos. ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)

Dorchester Co.

## PARENTS

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed Dec 16, 1913

E. E. Elwes

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 16, 1913  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 1913, to ..... , 1913,  
that I last saw him alive on ..... , 1913,

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH \* was as follows:

Still birth

Contributory  
SecondaryBlanched  
(Duration) yrs. mos. ds.  
(Signed) Dec 16, 1913 (Address) Lambsden\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death ..... yrs. ..... mos. ..... ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Saunders Ridge, Md. DATE OF BURIAL  
Dec. 17, 1913

## 20 UNDERTAKER

Eddie Graves ADDRESS  
Blundell Creek, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
Dorchester  
County

21640 (G)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Cambridge (No. 100 Post Master St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup> FULL NAME Surpren

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Female <sup>4</sup> COLOR OR RACE <sup>5</sup> SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Yes

<sup>6</sup> DATE OF BIRTH Dec 26, 1915  
(Month) (Day) (Year)

<sup>7</sup> AGE Still born  
yrs. mns. ds. If LESS than  
1 day, hrs. OR min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE (State or country) Md.

<sup>10</sup> NAME OF FATHER Mr. Surpren

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Md.

<sup>12</sup> MAIDEN NAME OF MOTHER Nealy Delohman

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Md.

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Draft Records  
(Address) Cambridge, Md.

Filed Dec. 31, 1915 Dr. W. J. DeWolff  
No permit issued, or certified REGISTRAR

Filed under 12/31/11 If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH Dec. 26, 1915  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from , 191 , to , 191 ,

that I last saw h alive on , 191 , and that death occurred on the date stated above, at , 191 .

The CAUSE OF DEATH \* was as follows:

Still birth

(Duration) yrs. mns. do.

Contributory Secondary  
(Duration) yrs. mns. do.

(Signed) Other secondary  
(Address) 208 High St. M. D.

Dec. 101 (Address) 208 High St.  
\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mns. do. In the State, yrs. mns. do.

Where was disease contracted, if not at place of death?

Former or usual residence

<sup>19</sup> PLACE OF BURIAL OR REMOVAL

Buried at Draft

DATE OF BURIAL Dec. 15, 1915

<sup>20</sup> UNDERTAKER Odeley

ADDRESS Cambridge, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

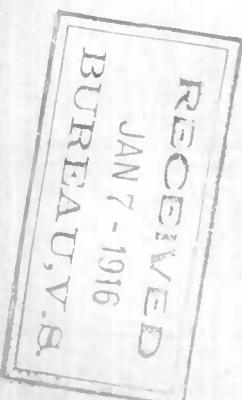
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return “*Laborer*,” “*Foreman*,” “*Manager*,” “*Dealer*,” etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is “*Epidemic cerebrospinal meningitis*”); *Diphtheria* (avoid use of “*Croup*”); *Typhoid fever* (never report “*Typhoid pneumonia*”; *Lobar pneumonia*, *Bronchopneumonia* (“*Pneumonia*,” unqualified, is indefinite); *Tuberculosis of lungs, menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); “*Cancer*” is less definite; avoid use of “*Tumor*” (for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as “*Asthenia*,” “*Anaemia*” (merely symptomatic), “*Atrophy*,” “*Col-lapse*,” “*Coma*,” “*Convulsions*,” “*Debility*,” (“*Con-genital*,” “*Senile*,” etc.), “*Dropsy*,” “*Exhaustion*,” “*Heart failure*,” “*Hæmorrhage*,” “*Inanition*,” “*Mara-mus*,” “*Old Age*,” “*Shock*,” “*Uraemia*,” “*Weakness*,” etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as “*PUERPERAL septicæmia*,” “*PUERPERAL peritonitis*,” etc. State cause for which surgical operation was undertaken. If for violent death, state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of “*Contributory*.” (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

\* PLACE OF DEATH 21641  
County Oxon Hill

Village or City Madison (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 118

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

66  
Alfred Wherry

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) Married

## 6 DATE OF BIRTH

1837  
(Month) (Day) (Year)

## 7 AGE

78 yrs. — mos. — ds.  
If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work Farming  
 (b) General nature of Industry, business, or establishment in which employed (or employer) 2

9 BIRTHPLACE  
(State or country)Md

## PARENTS

## 10 NAME OF FATHER

John Wherry11 BIRTHPLACE OF FATHER  
(State or country)Md

## 12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or country)Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

I (Informant)

John Wherry

## 15

File Dec 9, 1915 John R. Josler

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 7, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1915, to Dec 6, 1915,

that I last saw him alive on Dec 6, 1915,

and that death occurred on the date stated above, at 9 PM.

The CAUSE OF DEATH\* was as follows:

Hemp fever

(Duration) 14 yrs. — mos. — ds.  
Contributory Secondary Gastric Intestinal

(Signed) Victor Blazewill, M. D.  
(Address) Laurel

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Madison

## 20 UNDERTAKER

Louisa Bajnum

## DATE OF BURIAL

Dec 9, 1915

## ADDRESS

Chestertown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

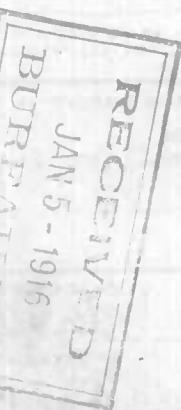
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Pianist*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return “*Laborer*,” “*Foreman*,” “*Manager*,” “*Dealer*,” etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Hauswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is “*Epidemic cerebrospinal meningitis*”); *Diphtheria* (avoid use of “*Group*”); *Typhoid fever* (never report “*Typhoid pneumonia*”); *Lobar pneumonia*; *Bronchopneumonia* (“*Pneumonia*,” unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); “*Cancer*” is less definite; avoid use of “*Tumor*” for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as “*Anæmia*,” “*Anæmia*” (merely symptomatic), “*Atrophy*,” “*Collapse*,” “*Coma*,” “*Convulsions*,” “*Debility*” (“*Con genital*,” “*Senile*,” etc.), “*Dropsey*,” “*Exhaustion*,” “*Heart failure*,” “*Haemorrhage*,” “*Inanition*,” “*Mars mutis*,” “*Old Age*,” “*Shock*,” “*Uracmia*,” “*Weakness*,” etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as “*PUERPERAL septicemia*,” “*PUERPERAL peritonitis*,” etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of “*Contributory*.” (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County		21642 Dorchester Co
Village or City		Canbidge nd Jem Lain St, Ward
2 FULL NAME		William Wright
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <small>(Write the word)</small>
Male	Caled	Single
6 DATE OF BIRTH		
Dec 6 (Month) (Day) 1915 (Year)		
7 AGE	If LESS than 1 day, hrs. yrs. mos. 6 ds. OR min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		
(a) Trade, profession, or particular kind of work now (b) General nature of industry business, or establishment in which employed (or employer) now		
9 BIRTHPLACE (State or country)		
Canbidge nd Sarah Wright		
10 NAME OF FATHER		
Sarah Wright		
11 BIRTHPLACE OF FATHER (State or country)		
Md		
12 MAIDEN NAME OF MOTHER		
gertrude addams		
13 BIRTHPLACE OF MOTHER (State or country)		
Md		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Sarah Wright (Address) Canbidge Md		
15 Filed Dec 12, 1915 E. W. Wolf		

V. S. No. 1.

STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. 116		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH	Dec. 11, 1915 (Month) (Day) (Year)	
17 I HEREBY CERTIFY, That I attended deceased from m dec. 11, 1915, to , 1915, that I last saw him alive on dec. 11, 1915, and that death occurred on the date stated above, at 110 m. The CAUSE OF DEATH * was as follows:		
Inanition cause unknown		
Contributory Secondary (Duration) yrs. mos. ds. Circumstances		
(Signed) E. W. Wolf Dec 12, 1915 (Address) Canbidge Md (Duration) yrs. mos. ds. M. C.		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. in the State, yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence		
19 PLACE OF BURIAL OR REMOVAL Kambidge Md DATE OF BURIAL Dec 12, 1915		
20 UNDERTAKER Lewis & H. Bryan ADDRESS Canbidge Md		

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . .  
name origin; "Cancer" is less definite; avoid use of  
"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Manasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renaker wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

21643

County Dorchester

(5)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. ....

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Cambridge No. ....2 FULL NAME Infant Young

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Dec 27, 1915  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min. ?stillborn

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ira C. Young(Address) Cambridge, Md

15

Fled Dec 28, 1915 Edwolff

REGISTRAR

DATE OF BURIAL

16 PLACE OF BURIAL OR REMOVAL  
Cambridge

20 UNDERTAKER

ADDRESS

Ira C. Young Cambridge Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 27, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased on Dec 27, 1915, to 191,that I last saw him alive on 191,and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Premature Birth

(Burial) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Edwolff yrs. mos. ds.

191 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Ira C. Young Cambridge Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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